



Cadets March Proudly
(Page 43)

the MODERN HOSPITAL

VOLUME 65 AUGUST 1945 NUMBER 2

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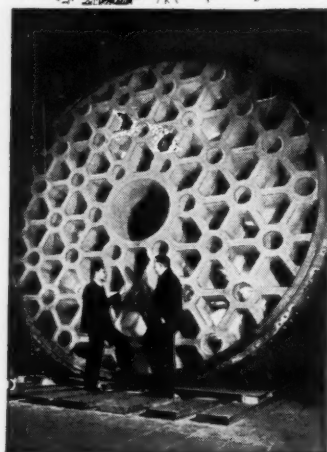
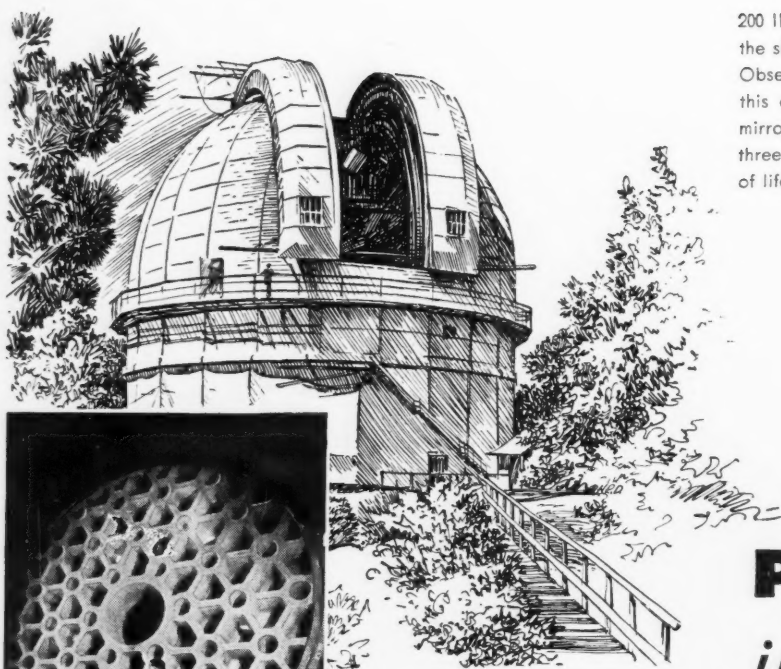
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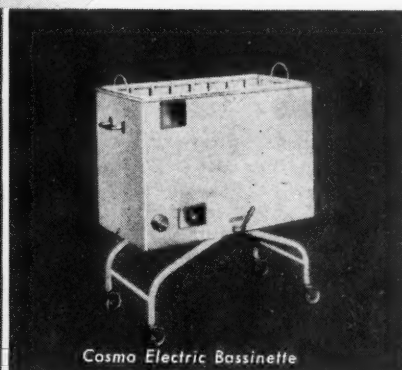
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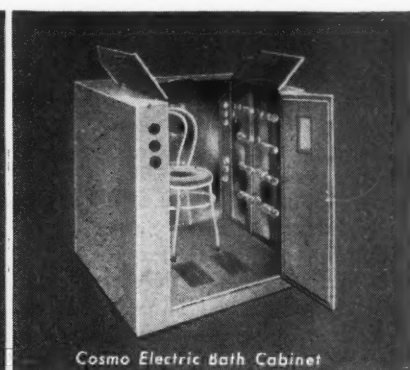
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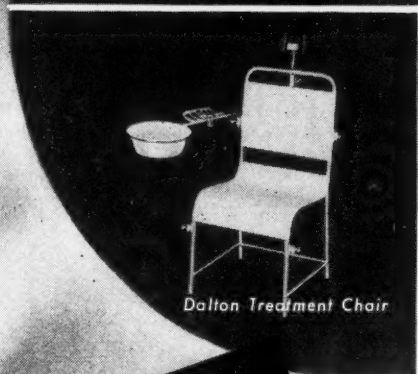
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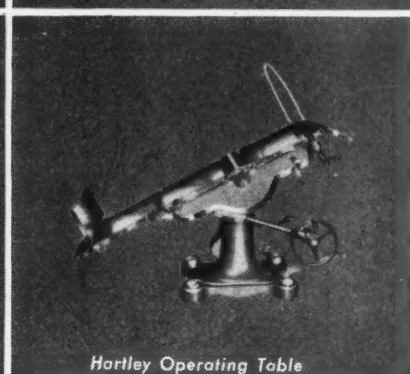
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Cadet Nurses from Provident Hospital, Chicago. Photograph, Courtesy, Chicago Sun.

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Health, Hospitals and the Negro

EUGENE H. BRADLEY

Administrative Assistant, Lincoln Hospital, Durham, N. C.

IN 1944 there were 124 Negro hospitals in the United States catering exclusively to colored patients. The bed capacity of these hospitals was 20,800, including 800 bassinets. These institutions were located in 23 states and the District of Columbia. Of these hospitals, 12 were governmental and were operated by federal, state or municipal governments and 112 were nongovernmental, operated by church, fraternal, community or proprietary organizations.

The geographical distribution of these institutions was as follows:

Ala.	9	Miss.	4
Ark.	5	Mo.	7
D. C.	3	N. J.	1
Fla.	11	N. C.	13
Ga.	8	N. Y.	1
Ill.	2	Okla.	4
Ind.	2	Pa.	3
Kan.	3	S. C.	7
La.	1	Tenn.	4
Mich.	10	Tex.	7
Md.	4	Va.	10
Del.	1	W. Va.	4

Only 23 Were Approved

Of these 124 hospitals, 23 were fully approved by the American College of Surgeons and three were provisionally approved. Of the approved hospitals, nine were approved by the Council on Medical Education and Hospitals of the American Medical Association for the training of interns. Seven were approved for residencies and two, for graduate training in surgery or a surgical specialty. Schools of nursing were conducted in conjunction with 20 of these hospitals. As can be seen, the majority of Negro hospitals are located in the South and most of the approved hospitals are also located in this region.

The institutions in the North are located in a few large cities: Philadelphia, New York City, Detroit, Chicago and St. Louis. While they render service in their respective Negro communities, other hospitals in these cities admit colored people

and there is no legal segregation of white and Negro patients.

The bulk of the Negro population is concentrated in the South and, because of the social structure of this region, more institutions for colored people are found in this section. This is not to say that Negroes are refused admission to some white southern hospitals but merely that these admissions are generally confined to teaching or governmental institutions or to the segregated wings of subsidized voluntary hospitals.

The relation of the colored population to the white population presents an interesting study for it is here that one will get an idea of the health and hospital problem of the South. The Negro constitutes approximately 31 per cent of the population of this region, or 9,904,619 out of a total population of 31,658,578.

In comparison with other states, Georgia presents an illustrative example. This state has a total population of 3,123,723 of which 2,038,278 are white and 1,084,927 are Negro. In 1944 Georgia had only 41 hospitals approved by the American College of Surgeons and none of these was Negro, while Wisconsin, with a total population of 3,137,587, had 81 approved hospitals all of which admit Negro patients without segregation.

These figures are not given as a statistical review but to show the importance of the Negro hospital in the South. The social tradition of the South does not permit the grouping of white and colored patients, nor does it permit (with few exceptions) the training of colored medical personnel in white hospitals. The colored nurse must be trained and this instruction must be received in separate institutions.

The Negro physician must be in a position to treat his patients and by virtue of the fact that he is not allowed to practice in white hospitals,

the colored hospital offers him his only opportunity in this regard. The teaching hospitals and governmental institutions that do admit colored people will not allow the Negro physician the privilege of attending his patients. Because of these factors and the sociological problems that are involved, the Negro patient prefers to receive treatment in those hospitals operated by the members of his own race. Such is the case and as a result a number of interesting facts must be observed.

They Do Well With Little

These hospitals in most instances are administered by Negro administrators and considering the handicaps they encounter are doing a fine job. In the majority of institutions the equipment is outdated and the physical plants are in need of modernization. Most white nurses would rebel if they were forced to contend with the antiquated equipment that confronts the colored nurse. But in spite of this, there is always that burning desire to give service.

The prime needs of Negro hospitals in the South are for better trained administrators, more modern equipment and sufficient funds to render the type of professional care found in the better white hospitals. It must be remembered that the necessity for better hospitals is not confined to Negroes alone. In many sections hospital facilities and medical care for white patients are also sorely inadequate. In a number of these conditions the problem is economic in character while in others it is due to inertia and lack of planning. The need for better medical care for the citizens of the South is recognized by the colored hospitals and they are doing their best under the conditions they must endure.

The point to be remembered is that the Negro hospital is entitled to the same type of good business management, medical staff organ-

ization and nursing service that exists in other institutions if there must be a dual sharing of responsibility for the health and well-being of the South. Southern states have for a long time stood far down on the list when it came to the provision of health and hospital facilities for all of their citizens. In a measure this factor is still one of finance. The South, because of its unfavorable economic position, is not able to afford the type of health care found in the more prosperous states.

They Travel 100 Miles

In the South the Negro hospitals are found principally in the larger cities but 75 per cent of the colored population will be found in the rural areas. This is regrettable because the very people who need good medical care are denied this service for lack of hospital facilities. I have seen patients come as far as 100 miles in order to be hospitalized. I have also seen the grief and hardships these people must suffer in their quest for hospital accommodations.

The lack of facilities also expresses itself in the general health of the population. A survey of the statistics of the U. S. Census Bureau will show this disparity in relation to the causes of death. For example, the total deaths from tuberculosis in 1941 numbered 42,283. Of this total 17,702 were Negroes. The deaths from syphilis totaled 17,728, of which 6420 were colored; from pellagra, 1836, of which 693 were colored.

In the diseases of pregnancy, childbirth and the puerperium the death rate per thousand births for the white population was 2.7 while that for Negroes was 6.9 per thousand. While these figures are for the nation at large, the ratio for the colored race is accelerated by the reason of the South's high percentage of Negroes.

A number of organizations in the hospital and medical field are performing heroic services in the interest of Negro hospitals, nurses and physicians. The National Association of Colored Graduate Nurses is active in promoting good nursing education and raising the standards of training schools. There are 25 schools of nursing devoted entirely to the training of colored women. Eighteen of these schools are located in the South and this affords an

excellent opportunity for students to become acquainted with the health problems of this region.

The National Medical Association is an organization of Negro physicians and surgeons. The purpose of the association is to foster and promote the practice of modern medicine among colored practitioners. The colored physician in the South is put at a disadvantage in many ways. He is unable to become a member of local medical societies and is denied the privilege of staff affiliation in those institutions that do admit colored patients. This makes him an outsider in many respects. That is why it is so necessary that Negro hospitals be in a position to offer him the facilities to render good medical care.

In several hospitals there are bi-racial medical staffs. It is here that we find a wholesome cooperation and the interchange of professional knowledge is beneficial to both groups. It is in these hospitals that progress is being made in all matters that affect Negro health.

The National Conference of Hospital Administrators is designed to promote and foster better administrative control and management. Through frequent conferences, literature and the interchange of ideas, an effort is made to see that the administrative organizations of member and other hospitals are enlightened to follow the principles of good hospital management. Through its efforts Negro institutions are prompted to become members of the American Hospital Association and to ally themselves with all progressive societies in the hospital field. It acts as an information bureau to dispense advice and offer suggestions to improve the service of all hospitals and to obtain able administrators for colored hospitals.

In hospital administration the Negro institution is below par in many respects. Gone are the days when any person regardless of prior training can be entrusted with the management of a hospital, white or colored.

At the present time the absence of good diagnostic facilities and medical records is the one obstacle that prevents the majority of Negro hospitals from being approved by the American College of Surgeons. This is due in part to the lack of trained personnel to perform the du-

ties associated with these services. There is little laboratory and x-ray service and the service that is rendered is not of the best technical and professional quality. Until the necessary personnel is found to operate the laboratory and x-ray facilities and until there is a unified system of records the majority of colored hospitals will fail to meet the minimum standards of the college.

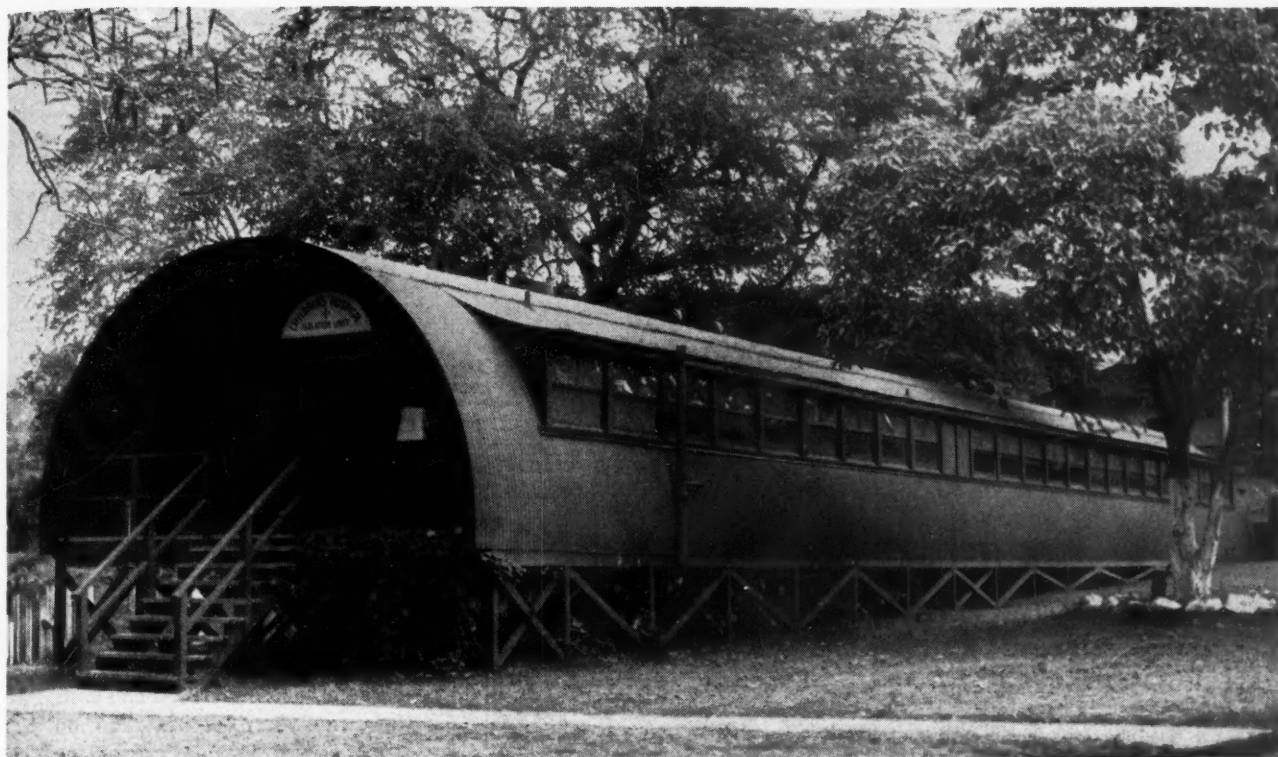
As the Negro hospital is contributing a real service to the community and to the general public welfare, it is necessary that it be given all possible support. It is impossible for one third of the population of a region to be deficient in good health protection without the other two thirds being affected.

The colored hospital needs encouragement and constructive criticism for it is the basic cell of health protection for thousands of citizens. It is apparent that this hospital is necessary in any plan of public health and particularly in the South where the great majority of the Negro population is concentrated. Then, too, it is to the Negro hospital that the colored man goes for advice or is sent by his physician for hospitalization. By working hand in hand with local and state health authorities it can become an essential part of any plan for the benefit of the public welfare.

Some Progress Has Been Made

In conclusion I wish to say that I do not imply that forward steps have not been made to improve the health condition of the southern Negro. Great progress has been made in this regard during the last fifteen years and the cooperation that exists between health officials and colored health workers is one of mutual respect and gratitude. Conferences are held periodically to discuss the Negro health problem and the progress that has been made from these discussions has proved to be an inspiration to both races.

North Carolina has made notable progress in the field of public health. The state commission on hospital and medical care inaugurated by Gov. J. Melville Broughton has made far-reaching proposals that will affect the well-being and health of all citizens of the state. The principles outlined by this commission could, in a measure, be adopted by other southern states.



ISOLATION WARD AT CHILDREN'S HOSPITAL, HONOLULU

First Aid for Housing Needs

R/A LUCIUS W. JOHNSON (MC) U.S.N.

District Medical Office, San Diego, Calif.

FOR many months hospital construction has lagged far behind the needs in many communities. Crystal balls have been bursting asunder from the strain of three-shift gazing by hospital executives who were losing sleep from worrying about their building problems.

Aided by the Lanham Act, many hospitals have been able to construct buildings that added to the bed capacity, but not service buildings. This served to emphasize the need for kitchens, offices, laundries, storehouses, employes' quarters and other facilities which were required by the increased number of patients. Such structures have been exceedingly hard to get.

The ideas and opinions here expressed are the personal views of the writer. They are not to be regarded as the policy of any government department. All illustrations are official U. S. Navy photographs.

V-E Day offers some promise of relief for the harassed administrator. It is likely that there will soon appear, in the lists of excess government materials, Quonset huts and other types of advanced-base buildings which have been produced in enormous quantities for the use of the armed forces.

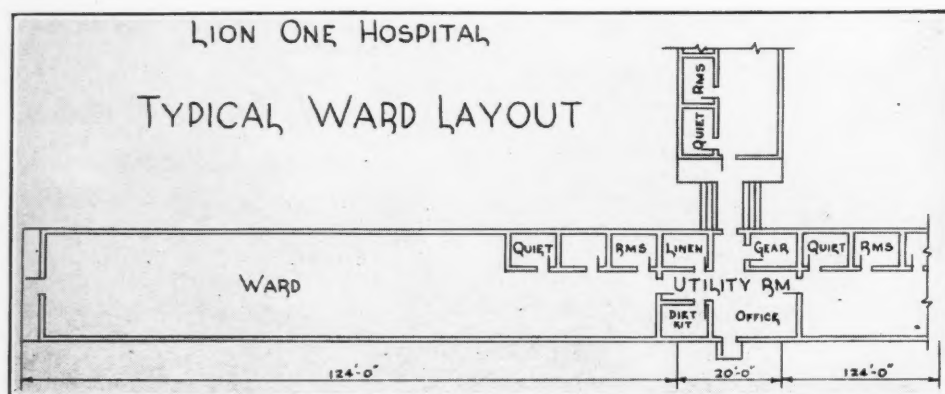
When war became imminent, it was quickly realized that emergency housing would be required for millions of men, both at home and abroad. The Navy's problem was given to a board of constructors, and their researches, conducted at the Naval Base at Quonset, R. I., were most successful. The type of hutment they produced takes its name from that naval base. The requirements were that the buildings must be easily transportable, quickly erected with a minimum of skilled

labor and afford protection from cold, hot or wet weather.

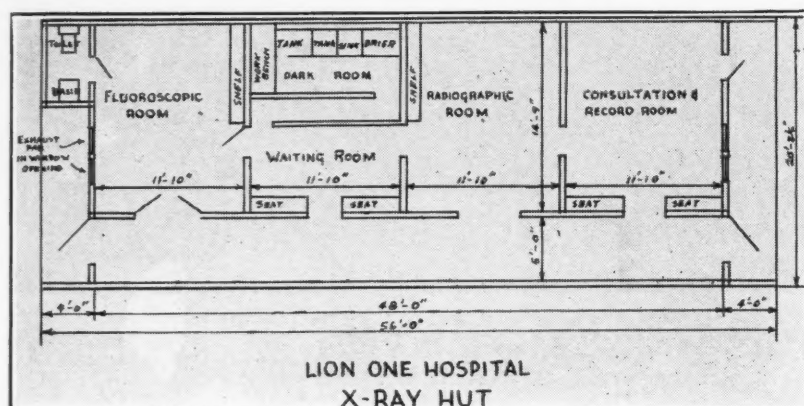
The standard structure was modified for many special hospital purposes, such as wards, clinics, kitchens, mess halls, quarters, storehouses, laboratories and operating suites. Special plumbing, electrical and other fittings were devised and the complete units were turned out by the thousands. Contractors who have been producing these buildings will undoubtedly be quick to sense the need for them in peace time, and they will be prepared to meet this demand.

Component parts of Quonset huts come in bundles, crates and boxes which are designed to be easily transported by ship or by truck. Little skilled labor is required to erect them. As soon as demobilization begins, there will be in every community of the country former service men who have had experience in putting up Quonset huts. The hospital corpsmen of our Lion I Hospital unit, without previous training, learned how quickly under instruction by the C. B.'s. A surprisingly small number of man hours of labor is required to erect these huts.

The standard size is 20 by 48 feet, but they can be combined in any multiple of 4 feet in length. There

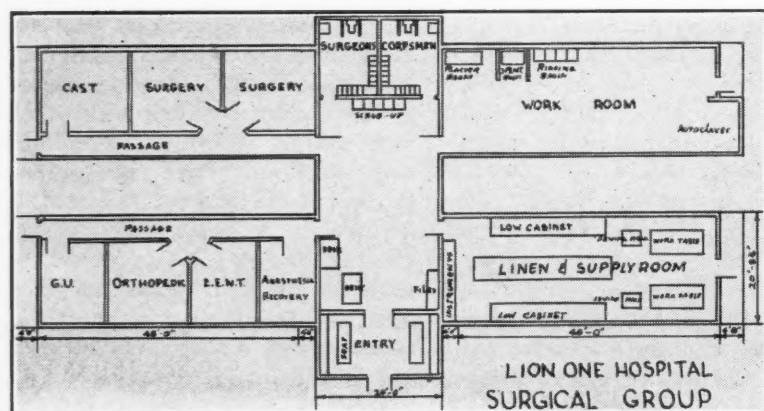


Typical floor plans showing the adaptability of the Quonset huts to any special need. The wards used at Lion I Hospital were T-shaped, each member of the T being 120 feet long. Another T-shaped unit was used for out-patient work. The surgery group consisted of 4 huts connected by a frame structure and a single hut became the x-ray room.



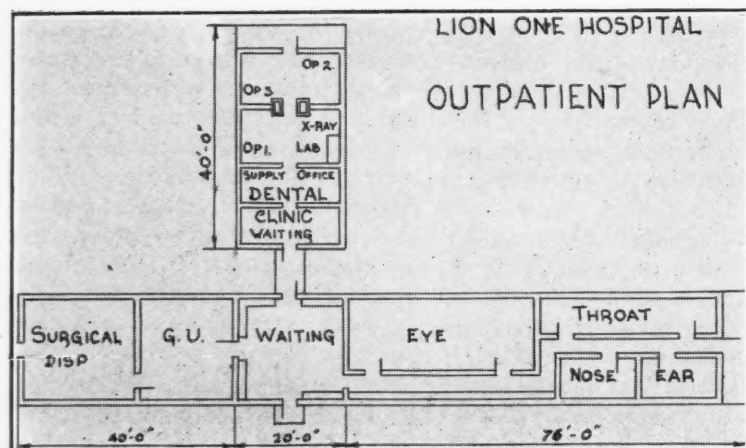
are also the larger 40 by 100 foot Quonset huts, which are usually erected on a concrete base.

For our hospital in the Southwest Pacific, we adopted a standard T-shaped ward. Each member of the T was 120 feet long and, where the three members joined, a frame structure was erected which contained the linen room, diet kitchen, doctor's office and a place for storing wheeled stretchers, with blanket storage above. Each of the three parts of the T accommodated 50 beds and with this grouping one doctor was able to care for 150 patients. We found it most economical of personnel. Others preferred H-shaped wards with toilets and other utilities in the cross member.



We quickly learned the economy of personnel that results from large wards. The longer we built them the better the patients and doctors liked them. Our final effort was 20 by 340 feet, and this last ward was considered the best of all. If that was not the longest ward in the world, it was at least in the upper brackets.

First step in erection were the footings. We used coconut logs at first but the wood borers moved in and ate them up in a jiffy. Concrete or terra cotta building blocks are very satisfactory for footings. They are permanent and can be easily chipped to the exact size needed. On these the girders are laid, and on the girders, the joists. They are light steel shapes, secured in place by nuts and bolts or tapered screws. The curved overhead members are secured to the horizontal joists in the same way.



Flooring comes in 4 by 8 foot plywood panels, which are screwed down to the joists. Since this floor is light and springy, heavy units, such as safes and x-ray tables, should

have special bracing underneath or be carried on concrete piers which are easily provided. Windows of plexiglass, and with screens, come carefully packed in a crate. In warm countries a continuous dormer, the length of each side, gives excellent circulation of air. The ends of the building are of canvas with a large screened opening, for which a rolled canvas curtain gives protection against rain. For colder climates plywood ends and solid doors are provided.

On the overhead members is applied first the lining of fiber board; then comes a layer of crêpe paper insulating material, and then the corrugated iron plating. There is an air space of about 4 inches and the insulation is so effective that at the equator the temperature inside was about 4 degrees lower than that in the deep shade under the mango and breadfruit trees outside.

Our hospital was erected in a coconut grove. As the rows of the trees were 8 meters apart, our 20 foot buildings fitted snugly between them. It was essential to preserve the trees for camouflage and the value of this was proved whenever Sewing-Machine Johnny made his moonlight visits. One night he laid a stick of bombs right down the middle of the camp. You would have thought the place was so congested that one could not have dropped an egg without splattering



A minimum of skilled labor is needed in the construction of the huts.

several people, but the bombs did not damage a road, a building or even injure a person. One cow was killed and we interred her with appropriate ceremonies, using her tombstone as a warning to the foolhardy.

If it is desired to make the Quonset huts inconspicuous, this can easily be done by painting. Partitions can be fixed or movable and can be easily made by any hospital carpenter.

While I was on duty in Honolulu, an emergency arose which made it necessary to provide additional space for isolation in the Children's Hospital. It was possible to obtain Quonset huts for the purpose and the result was a pleasant, efficient communicable disease ward.

The examples shown are designed to stimulate the imagination, and I have no doubt that any hospital administrator who is in need of emergency construction will find a way to adapt these buildings to suit his needs.

While the accompanying pictures show Quonset huts as used in warm countries, they gave equal satisfaction in Alaska and the Aleutians. Oil-fired space heaters, especially designed for use in these huts, will probably also be found in the government's lists of excess material. It is worth noting that the materials for fabricating the huts are so packed that they can be stored in the open, under tarpaulins, for long periods without serious deterioration.

Hospital administrators who have urgent building needs should give careful consideration to the possibility of obtaining Quonset huts for the purpose. The pictures and floor plans shown here will serve to suggest their wide range of adaptability to hospital uses and seven months of living in one taught me how comfortable they can be.



Details of cubicle arrangement in a ward at Children's Hospital.

REPERCUSSIONS

from the Architectural Contest

AN ARCHITECT ARISES TO INQUIRE

T. F. ELLERBE

Ellerbe and Company, Architects and Engineers, St. Paul, Minn.

A PUBLISHED critical analysis of The MODERN HOSPITAL architectural competition is much needed for the benefit of prospective hospital builders because the submitted results failed to live up to the competition's objectives of providing hospitals that are "efficiently arranged, suitable for smaller communities" and "economical to build and to operate." The jury's unanalytical comments failed to warn the public of the deficiencies either in the program or in the submissions.

Contrary to Mr. van der Rohe's statements that "architects have no business to be talking like bankers" and "economics is not their main concern," modern hospital planning is definitely an economic problem as any hospital board, administrator or architect who has had to do with designing a small hospital building can readily testify.

Must Consider the Cost

Because of the limitations of our present economy, a hospital designed as "ideal" without regard to cost cannot be built in any but the most unusual circumstances where liberal subsidies can be provided. A truly ideal hospital must take into account the cost of providing hospital service and, therefore, the cost of building and operating the plant and the source of funds to meet these costs, or else it will defeat its own primary purpose, the care of sick people.

It is impossible, as Mr. van der Rohe suggests, to design a good building and construct only as much as is consistent with a perfect plan. If the perfect plan was developed and proved too expensive, would one build the perfect plan minus a few beds or minus a few facilities? If beds are omitted, the facilities are too elaborate and, consequently, uneconomical. If the facilities were decreased, the operating cost would be

less, but the results would be far from perfect.

Much of the difficulty of the competition stems from the requirements of the original program. These requirements are much too extensive, elaborate and, consequently, expensive for the average community requiring a 40 bed hospital. The suggestion that the building be one story indicates a disregard for original costs inasmuch as a one story building is more expensive than a two story building if fireproof construction is considered.

Two operating rooms, physicians' scrub room and workroom, in addition to sterilizing room for a maximum surgical bed capacity of 20, or two operations a day, are, to say the least, elaborate. Likewise, two delivery rooms for an average of one delivery a day are excessive.

Other desirable, but certainly not essential, requirements in the program are a doctors' suite, medical library and bedroom and bath for administrator. The results of these extensive requirements are demonstrated by the fact that most of the mentioned plans have an excessive amount of cubical contents.

This is particularly true of the prize-winning design (see page 50) which has more than 400,000 cubical feet. If 50 cents per cubic foot, which is an extremely low figure for such an elaborate building under present conditions, were applied, the cost per bed amounts to more than \$5000, not including equipment. This is more than the average community can undertake.

Even though the original cost at that figure were subsidized, such an elaborate plant would cost so much to operate that a substantial per bed subsidy would be required to operate it on the basis of the charges that now prevail.

As a matter of fact, the prize-winning design is unique in several respects. It has failed to take advantage of some of the important savings that might accrue in a one story building, namely, the omission of stairs and elevators. This building has three stairways and, believe it or not, two elevators—one running three floors! Elevators are expensive to install and operate.

Everything in Duplicate

In fact, this design completely disregards economy since it has two boilers, two air-conditioning systems, two private suites on the second floor and an amazing total of 22 water closets for the convenience of the staff and visitors and only nine for the convenience of the patients or the nurses in the process of patient care. The extensiveness of the surgical layout, delivery department, necropsy, laundry and culinary service is ample for a building of from 65 to 85 beds.

Further indication of disregard for economy or convenience is in the east wing which includes a passage to the garden. The distance past this passage must be traversed dozens of times a day in caring for the patients in this wing compared to an occasional trip to the garden. Another instance of disregard for economy is

having rooms only on one side of the corridor. This makes the average distance of travel from the nursing station twice as far as if rooms were on both sides.

The inclusion of this arrangement is no doubt accounted for by the designer's desire to have sunlight in all rooms. Sunlight is desirable but is in no way essential, and no convenience in plan should be sacrificed for an attempt to obtain it. The benefits from sunlight in the average general hospital, where the stay is approximately ten days, are purely psychological. As a matter of reality, bright light is disadvantageous in many cases.

The inclusion of four beds, or 10 per cent of the hospital capacity, in an isolation suite is unwarranted as one communicable case in this area makes unavailable for general hospital use four beds, actually reducing the hospital capacity by that much.

The location of the future expansion is exceedingly unfortunate, if not impossible. It would draw all traffic to this section through the obstetrical unit and also place it an excessive distance from the administrative center.

Fourth Should Be First

The most compact and efficient solution to the competition is fourth honorable mention. This plan has more of a chance of complying with the objectives of the competition than do the others. There does not seem to be any particular point in publishing such an impossible design as No. 5, whose chief claim to fame is based on demountable partitions. These are undesirable in the first place on account of noise transmission and, in the second place, could not be demountable on account of the numerous outlets required in them. One also questions the wisdom of publishing the weird contraption with the trapped light and stilted second floor.

The bold and forthright comments of the jury in a recent prominent competition seem entirely applicable in this case. "To the jury it seemed that entirely too many were inferior in quality and suggest a discouraging outlook. Although almost half of the designs came from registered architects who should be presumed to do good architecture, there was a pronounced lack of . . . sound realism."

And the

PRIZEWINNER

Makes Reply

ALAN FISHER

Fisher and Fisher, Architects, Denver

WE ARE much interested in Mr. Ellerbe's clear and complete letter of comment and criticism. We assure you that a letter written by a man of such attainment as Mr. Ellerbe has received thorough study by members of this firm and that considerable discussion has resulted, not only within this office but with other architects and hospital administrators in this area.

In commenting on the criticism of Mr. Ellerbe, we have decided to take up the matters that are mentioned relative to our submission only. We will take each matter in the sequence in which it has been presented by Mr. Ellerbe.

In general, it is agreed here that Mr. Ellerbe's comments relative to the small county general hospital stem from an overstrict philosophy of economy—economy both in original costs and in operating costs. We cannot concur with such philosophy inasmuch as the care of the sick is, or should be and will become, the most important consideration related to public expenditures.

Equipment, services and other factors having to do with the care of sick persons must be heavily subsidized by public money and, if necessary, an intensive educational program must be instituted and pressed unceasingly until public officers, trustees and administrators are cognizant of these facts.

Currently, this office is studying the painful cure for two sick county hospital units in this area. In each case the hospital was started new and relatively recently, in the 1920's. In each case, economy of building and operation was practiced. In each case this economy has proved almost fatal to the plant. In one case we

feel that it might have been better to have closed the doors and walked away from the project entirely, a project representing an "economical" expenditure made in 1926.

The cure of this unit, in order to create a workable hospital, requires the inclusion of facilities that are far too elaborate and extensive in the eyes of Mr. Ellerbe but necessary to the operation of a small acute general hospital. The incumbent commissioners are now deeply aware of the expensive tragedy imposed upon them and their county by their economy-minded predecessors.

\$5000 Is Too Modest

Returning to Mr. Ellerbe's references pertaining to the submission of this firm, the first comment states that such a hospital would cost more than \$5000 a bed. That is a modest estimate, as our figures submitted to you show a cost considerably greater. On no occasion in recent years has this firm represented to county commissioners or building committees that a general hospital can be erected for as low a cost as \$5000 a bed, not including equipment.

Currently, we are working on a 200 bed county hospital (not referred to previously) and our sights are adjusted to a figure slightly higher than the \$5000. If this is true at 200 beds, the 40 bed hospital must run considerably higher, as bed costs rise in inverse proportion to the number of beds. The average community will have to face these facts as to expenditures for plants and operation if it wishes to operate this most vital of all county adjuncts successfully.

Criticism related to the three stairways and two elevators in a one story



building is perhaps a little over-emphasized by Mr. Ellerbe, as the building is actually not a one story structure. Further, one stairway is an outside areaway flight providing service and access to the mechanical area. We have never been guilty of omission of this feature in any type of building containing any sort of mechanical department. The second stairway provides a service and employees' entrance to the building, thus relieving the interior stairs of this somewhat undesirable traffic.

There are an elevator and an expensive hydraulic lift. If the lift were omitted in actual construction of such a building, hospital operation would inevitably demand its installation at greater cost at some future date. Experience has proved this time and time again, and elevator company records strongly substantiate this fact. Furthermore, "believe it or not—one running three floors!" proves that the building is not a one story structure, as Mr. Ellerbe contends.

The extension of an elevator run is an infinitesimal portion of the cost of elevator installation, inasmuch as only a small additional amount of guide and cable is necessary along with a minor amount of automatic operative equipment. Why not make full use of the initial elevator installation?

In the matter of extensiveness of surgery and obstetrical layouts, we hold that the program requirements specified these services rather rigidly. We feel that the person, or persons, responsible for writing these requirements into the program is to be commended for his foresight and knowledge of hospital operation. We feel that the culinary and laundry departments are not oversized. There is nothing extensive about the single necropsy room at 16 by 20 feet.

In the matter of the excess of travel past the garden access, where have we read something to the effect that good hospital buildings cannot be judged alone by a pedometer on the ankle of a pretty nurse?

To explain a greater number of water closets provided for help and staff than for patient use, it should be remembered that the help and staff constitute a group of normal persons living a normal life and attending to necessities in a normal manner. In most cases, a hospital patient finds that his life becomes

a thing temporarily separated from water closets or the use thereof.

The matter of the necessity of two boilers in a hospital plant is so vital and broad in scope that we are treating this question of duplication separately. We are enclosing herewith excerpts from a letter from a heating engineer (see below) that is a part of a mechanical report on an actual project being prepared for this firm.

The consideration of the location of future expansion came from a desire to achieve a future maternity department well separated from the other hospital departments, yet well correlated to the obstetrical division. We are unable to see why Mr. Ellerbe flatly states that it won't work.

There is no question but that such a separated nursing unit for 20 beds in a 60 bed hospital is entirely feasible and desirable. If the coefficient of 20 beds proved to be too high for

maternity alone, in actual operation, there should be no objection to the use of some of these 20 beds for female patients whose cases are entirely clean, such as coronary cases.

We were perturbed over the fact that Mr. Ellerbe minimizes psychological benefits as elements of curative importance. We have always been under the impression that the psychological condition of a patient is related one way or the other to his physical condition. And we wish further to point out that disturbing noises from a necessarily noisy service court (coal deliveries, ice deliveries, provision deliveries, ambulances, hearses, the coming and going of doctors and employees, the flashing of doctor's car lights in the night) are detrimental to patient care and, perhaps, more concrete in effect than are the purely psychological elements.

EXCERPTS FROM ENGINEER'S REPORT

REGARDING the matter of boiler installation, it is to the interest of good heating practice that two boilers be used. The theory in this is to size each boiler at approximately 70 per cent of the maximum load. On this basis, therefore, one boiler will handle a normal load about 80 per cent of the time. The maximum load actually means heating conditions at outside temperature from -10° F. to -70° F., all sterilizers in operation, 100 per cent domestic hot water load and the laundry operating at full capacity.

It is common sense to know that this condition will not occur, so what might be a 500 h.p. maximum load will probably be a 300 h.p. load during most of the operating time. We know that greater boiler efficiency is maintained under full capacity and not when a boiler of larger capacity is operating on only a fraction of its potential output.

For example, summer night loads might dwindle to 100 h.p., as the heat is off, the laundry is off and only a small percentage of domestic water is in use, and probably the sterilizer capacity is at a fraction of its day requirement.

In all designs today we are careful to install duplicate feed pumps, vacuum pumps, hot water generators and, in some institutions, auxiliary power units for lights and elevators.

From this it seems to be poor judgment to install a single boiler unit which is, of course, the heart of the entire mechanical plant.

In a two-boiler installation the actual condition then will be that one boiler handles the entire load. However, if necessary at times of greater demand, the second boiler can be put into service. This creates an ideal condition because in the event of a breakdown one boiler can be kept in operation and handle the probable load while the necessary repairs are made to the broken boiler.

It is also good practice to operate one boiler for say a month or six weeks, while the other boiler is being cleaned and any necessary maintenance work is done. In alternating thus, the life of the boiler would be prolonged. Therefore, I cannot see why we should be so careful to duplicate vital equipment and then have only one boiler which might be put out of service because of a mechanical defect in the stoker, oil burner or heating medium equipment.

One other advantage of the two-boiler plan (each having a 70 per cent capacity of total load) is that both boilers in service could handle future expansion of hospital facilities, which is not usually provided for in power house construction and costs many dollars at some future date.

A PENSION PLAN

Will Help to Preserve Much-Needed Manpower

IN RECENT years hospitals have recognized the necessity and desirability of setting aside reserves for depreciation of equipment. This is generally regarded as good business. If it is sound practice to set up reserves for aging equipment, why not for aging manpower? Perhaps it is even more important to remove older workers whose efficiency has been impaired. To retain them may seriously interfere with the efficiency of the organization—not only because their performance may be below standard but because of the effect on others in related positions.

Retirement Is Sound Practice

If orderly withdrawal and replacement of worn-out and obsolete equipment is sound business practice, cannot the same be said of the orderly withdrawal of the aging employee and the promotion of younger men? A transfusion of younger men with ability, energy and ideas may mean, in the final analysis, a saving in the form of better morale, production and efficiency. For a number of reasons hospitals and other voluntary agencies have been slow to meet this problem.

In 1935 the University of Rochester made a careful investigation into employee retirement because of the exclusion of eleemosynary institutions under the Social Security Act and because of the inevitably expensive and inequitable handling of individual cases as they arose. In the following year a retirement annuity and life insurance program to provide joint purchase by the university and the employee was adopted. A well-known insurance underwriter was selected to administer the plan.

Strong Memorial Hospital is a unit of the University of Rochester and all of the hospital personnel was eligible to participate in the plan. The program has been in operation since 1936 and the following brief description of the plan, its advantages and

disadvantages, is an evaluation of hospital experience only.

Group annuity and life insurance are simply a means of affording retirement income and life insurance protection to all employees at wholesale rates. The retirement income is purchased over the employee's entire period of participation and payments for life begin on retirement. A single blanket or master policy was negotiated and issued to the university. Each employee covered by the insurance receives a certificate as evidence of his protection under the group policy. As employees have a greater tendency to leave during the early months of employment a waiting period of one year is required before an employee may participate.

The employee's retirement date is the sixty-fifth birthday. The first payment of an employee's retirement annuity, equal to the total amount provided in the following schedule, is made on the date the employee retires and subsequent payments are made monthly thereafter as long as he lives.

With the consent of the university, an employee may retire before or after his normal retirement date. In case of earlier retirement, the employee will receive a reduced scale of retirement annuity. In case of later retirement, contributions toward annuity will cease at normal retirement date.

The plan calls for the decrease of the life insurance coverage between the ages of 55 and 60 by five equal decrements to bring it to \$500, at which level it remains and is con-

tinued at the expense of the hospital after retirement.

In the event of an employee's death the life insurance and his contributions toward the annuity are payable to a beneficiary named by him.

Employees' contributions toward their annuity and insurance are deducted from their regular salary or wages and turned over to the insurance company together with the hospital's monthly contribution to cover the balance of the net cost. On termination of service, contributions cease and the employee has several options. He may elect

1. To convert his insurance without medical examination into any of the policies issued by the underwriter (term insurance excepted).

2. To have all his annuity contributions returned to him in cash.

3. To leave his annuity contributions with the insurance company and receive at age 65 the part of the annuity which has been purchased by his contributions. If the employee has been a contributor to the plan for ten years this option entitles him at age 65 to receive the entire annuity purchased by the university's contributions as well as his own.

Visiting Nurse Service Available

Employees may take advantage of a visiting nurse service without cost to them or the hospital. The advantages to the employee and to the hospital are obvious.

When the plan was adopted it was felt that some supplementary payment should be made to employees with a record of prior service. This

L. J. BRADLEY

Assistant Director, Strong Memorial Hospital
Rochester, N. Y.

Schedule of Salary Classes, Benefits and Employees' Contributions

Salary Class	Annual Rate of Salary or Wages	Monthly Rate of Retirement Annuity for Each Complete Year as Contributor in Salary Class	Life Insurance	Monthly Payments for Retirement Annuity	Monthly Payments for Insurance Benefits
A	\$1,000.01 to \$1,400.00	\$ 1.50	\$1,200.00	\$ 3.60	\$ 0.72
B	1,400.01 to 1,800.00	2.00	1,600.00	4.80	0.96
C	1,800.01 to 2,200.00	2.50	2,000.00	6.00	1.20
D	2,200.01 to 2,600.00	3.00	2,400.00	7.20	1.44
E	2,600.01 to 3,000.00	3.50	2,800.00	8.40	1.68
F	3,000.01 to 3,400.00	4.00	3,200.00	9.60	1.92
G	3,400.01 to 3,800.00	4.50	3,600.00	10.80	2.16
	etc. to maximum \$9,800.00 and over	etc. to \$12.50	etc. to \$5,000.00	etc. to \$30.00	etc. to \$3.00

was purchased entirely by the university, and the amount was set at 1 per cent of 1936 salary for each year of service after the employee had reached age 45, and $\frac{1}{2}$ per cent for each year before 45.

This brief description cannot contain the full details of the plan but it should give a rough outline of the major points.

In 1936 when the plan was presented to the hospital group, approximately 450 employees were eligible. Participation with this original group was voluntary and 66 per cent joined without pressure from the administration. This in itself was good evidence of the need and recognition of the value of the plan.

Participants in this original group were given the privilege of withdrawing at a later date for good reason. Twenty-one have withdrawn while continuing in the employ of the hospital. Eighteen of these resigned sometime after dropping the plan. Since the adoption of the program in 1936, participation has been effective for all new employees in the hospital.

Some Withdraw From Plan

It is to be expected that a small percentage of employees will question the value or request withdrawal after several years' contribution. Young people, especially young women, are not ordinarily interested in an event occurring so far in the future and married women, working for a few years to help the family budget, may question the value of participation.

During 1943 there appeared to be an unusually large number of such requests. On analysis it was found that the majority originated with the less stable group of employees; some, however, were legitimate and the reason was apparent. With increased taxes and rising costs of living, the

(Continued on Page 54)

Madison Has a Plan, Too

P. M. BROWN

Auditor, Madison General Hospital, Madison, Wis.

A RETIREMENT found and life insurance plan has been established by the Madison General Hospital at Madison, Wis.

This plan makes employees eligible to participate at the beginning of their sixth year of service if they are then 30 years of age. The hospital pays the entire cost of the premiums to a local trust company which holds the policies in trust for the employees and makes annual payments of premiums due to the two insurance companies which cooperated in setting up the plan.

Two members of the hospital board of directors and one hospital employee serve on the pension trust committee which takes care of all details of administration of the plan.

Employees are eligible to retire at age 65 with a monthly retirement income equal to: (a) 25 per cent of the monthly salary up to \$250 per month; (b) plus 15 per cent of that portion of salary over \$250 per month; (c) plus 1 per cent of total salary for each unit of five years' service over 15 years.

To illustrate: An employee who started at age 40 and who retires at age 65 with a salary of \$275 per month will receive for life a retirement income of \$71.75 per month.

In every case, if the employee should die before reaching retirement age, his beneficiary will be paid either:

1. The amount of life insurance carried and paid for by the hos-

pital on employees who were *insurable* at participation in the plan, or

2. The accumulated cash value or the total amount of premiums paid, whichever is greater, for employees who were not insurable.

One employee did die just a few weeks after this plan was instituted and his wife was paid \$462 which was the amount of the first premium.

Covered by Life Insurance

In addition to the retirement benefit, all eligible insurable employees are covered by life insurance and the cost is paid by the hospital. This is based on the monthly retirement income in the amount of \$1000 for each \$10 of monthly income. It will be noted that this plan has features that are different from many retirement plans now being adopted.

There is no accumulated cash credit or benefit to the employee who leaves employment prior to his retirement age as it is a noncontributory plan.

For permanent total disability, provision is made for a *reduced retirement* income for life.

A minimum of ten years' service after a new employee becomes eligible is required before retirement becomes possible. It is possible, however, for an employee who was over 56 when the plan was started to retire at age 65 on an adjusted basis.

Life insurance for those employees who are insurable is an extremely valuable feature.

(Continued From Page 53)

cost to the employe was just enough to strain the family budget. Normally, salary and wage adjustments lag behind increases in the cost of living. When adjustments in wages have been made, requests to withdraw have dropped markedly. As of Jan. 1, 1945, 86 per cent of the eligible employes were covered.

Has the plan provided tangible benefits for the hospital? While one of the objectives in setting it up was to fulfill a social obligation to employes of long service, the hospital expected benefits in the form of increased efficiency, improved morale and better employe and public relations. It may be said the plan has fostered good will and confidence between hospital and employes. It has tended to stabilize the working force during the recent difficult times. This is especially true among the middle income groups and key personnel.

In a recent personnel study the number of employes with ten years or more of service was surprisingly large in view of the lure of wages in industry today. Minor in the overall picture, but important to some, is the protection (annuity and life insurance) given to those who cannot afford to pay the usual premiums of individual policies, or who cannot pass standard insurance physical examinations.

During a recent study and evaluation of experience with the plan it was brought out that a better job might have been done in explaining its value and usefulness. Little has been done to "sell" the employe the true worth of the plan, the amount the hospital contributes, the number of individuals who have and are re-

ceiving benefits and the value of the options. The amount already paid to employes is surprisingly large. In short, the program has been presented, explained and forgotten.

The underwriter has a trained staff ready to serve the interests of the employer and employe in an educational program and no charge is made for this service. It is planned to use a series of posters to explain continually to the employe the various benefits of the program. Public relations is not likely to be harmed if visitors should see these posters. The public should be aware of what the hospital is doing. A reputation for providing for its aging employes may react to the hospital's advantage in a number of ways.

Cost may be considered a disadvantage, but will careful analysis bear this out? Admittedly, the current cost appears to be high, even prohibitive, to many hospital directors and boards of trustees. In 1937, at Strong Memorial Hospital, the net cost per patient day, excluding past service, was 9 cents. In 1944, after eight years of operation, the net cost was 18 cents, an increase of 100 per cent, although total patient days increased 16 per cent during this period. Considering the number of patient days this represents an appreciable sum of money.

The cost of a pension plan, of course, depends upon a number of variables, such as future and past service benefits, age and sex composition of the group and eligibility requirements. Future costs are difficult to forecast accurately. In 1944 the employe dollar was matched by approximately two hospital dollars. This cost to the hospital should tend

to decrease when the normal supply of young people is available to offset the rising age level of those already participating.

Hospitals that hesitate to offer a plan to their employes because of the cost might study carefully the effect of the aging employe on the efficiency of their organizations. Such an analysis may bring to light a hidden and often forgotten cost that does not appear on the income and expense statement. The problem of aging is serious enough with the ordinary employe but it is perhaps even more important in the supervisory and executive groups. Fixed ideas, lack of initiative and imagination may cost hundreds of dollars.

Industry has an advantage over hospitals and other nonprofit groups in that its costs can be turned to a tax advantage and this factor has probably influenced the extension and adoption of annuity programs. Hospitals have no such advantage.

A question may be asked, especially at this time, as to the necessity of a private plan in view of a possible revision of the Social Security Act to include voluntary nonprofit groups. At first thought it would seem that benefits provided under the act would relieve the employer of the necessity of granting supplemental benefits under a private plan.

Actually, industry has found that federal benefits are insufficient in many cases even when the employe is accustomed to only a moderate standard of living. High income taxes make it extremely difficult for the individual to accumulate savings enough to supplement the federal benefits and there is little indication that the tax load will be appreciably lighter for many years. In the low income group the problem is even more acute since for the first time these people have been called upon to pay high income taxes at a time when living costs have been increasing. The opportunity to accumulate savings is limited. So there is good reason for a private plan to supplement federal benefits.

The Social Security Act furnishes a good foundation and the cost of a private plan is much less than if the hospital has to bear the entire expense of an adequate pension plan. Plans may readily be adjusted to meet the need in the event of an extension of social security coverage to voluntary hospitals.

WRITE FOR YOUR VOLUME INDEX

If you bind your volumes of *The MODERN HOSPITAL* you will want the index to Volume 64, covering issues from January through June 1945. War-time paper rationing prevents its publication in the magazine. Write to 919 North Michigan Ave., Chicago 11.

Cascade Oxygen System

Reduces Risks and Costs

THE question of installing a piping system for oxygen at the State University Hospitals in Iowa City was studied from every possible angle for many months. A desire to provide a safer and a more economical flow of oxygen for therapeutic purposes was the motivating factor.

The hazards associated with handling the high pressure "K" cylinders are considerable. No hospital in which cylinder oxygen is used in great quantities can long avoid an occasional tip-over of a cylinder with consequent damage to equipment and possible injury to personnel and patients. The manpower situation being quite critical, it was estimated that a saving of approximately thirty minutes' handling time for each cylinder used within the hospital would be effected. Freight charges for transporting the cylinders from the vendor's plant to the hospital were a considerable item.

As the study progressed, it was found by actual measurement that many cylinders were returned from the floors with appreciable amounts of residual oxygen and yet the quantity was not large enough to warrant their being again sent to the floor for use. This added up to a sizable loss in the course of a year.

Space required for proper storage of cylinders was not always available where it was desired to use oxygen within the building and this itself was an item when hospitals are particularly crowded with patients. Also, the small trucks to handle the oxygen cylinders were necessary but always somewhat of a nuisance in that they were more or less always in the way.

In planning the central system, full advantage was taken of the engineering and architectural services available in the university's physical plant department. The vendor company was most helpful in submitting specifications and recommendations and furnishing answers to many annoying questions as they arose. This

VERNE A. PANGBORN

Director, Hospital Stores
State University Hospitals
Iowa City, Iowa

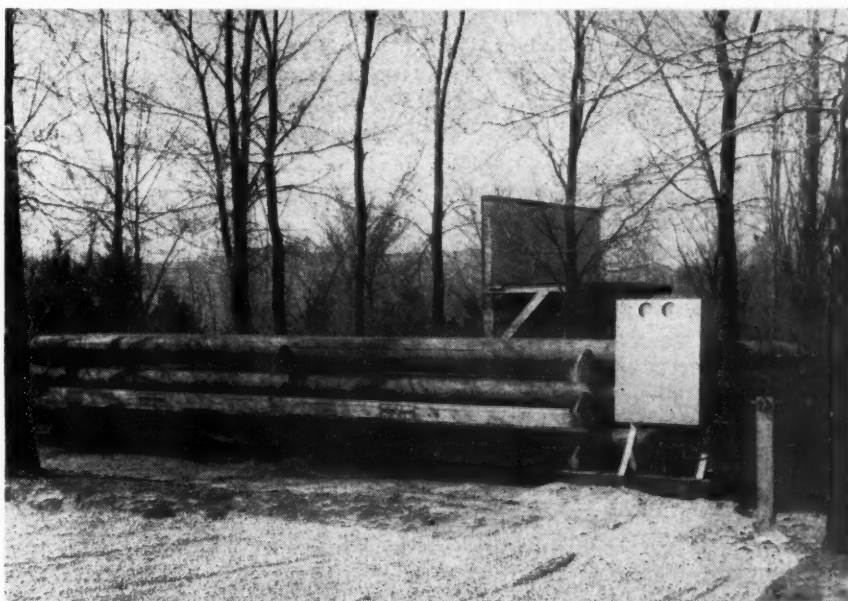
piping system would not be a mere plumbing job, it must be a means of providing a medication to patients whenever and wherever it was needed. Thus, the system must be reliable and, above all, must be absolutely clean and free from all impurities.

All piping in the system must be seamless copper tubing, type K, and meet government specifications for this type. All fittings for joining the pipe must be either wrought or cast copper fittings made especially for soldered connection. The solder itself should have a high melting point. The flux should be zinc chloride flux prepared with zinc and muriatic acid or similar type. (Note: Rosin and similar paste flux may contain compounds objectionable for oxygen service and must not be employed.) All section valves should preferably be of a bronze globe valve. Pressure gauges must be manufac-

tured especially for oxygen service and these must include gauges temporarily connected for testing purposes. The system should have a pressure relief valve, adjusted to relieve at 50 pounds per square inch above the working line pressure. An alarm should be connected to the system which will sound automatically if the pressure reaches 25 pounds either above or below the normal working pressure of 50 pounds p.s.i.

In the fabrication of all this material, all pipe valves and fittings and pressure relief valves must be washed thoroughly in a hot cleaning solution. After being washed, all materials must be thoroughly rinsed. After washing and rinsing the pipe must be carefully handled for should any dirt come in contact with the inner surface of either pipe, fittings or valves, they must again be washed and rinsed. Therefore, pipes and fittings should be washed only immediately before being assembled or installed.

It was decided that the piping in the system should be installed approximately 6 inches from the ceil-



Cascade storage unit. The panel box holds control valves and safety devices. To refill the unit, the truck connects to the outlet at right.

ing and supported at not greater than 10 foot centers by hangers as required. Drops from the line to the outlet should be fastened to the wall by means of clamps as specified by the architect. Holes in walls or ceilings should be covered with a proper flange or washer. All outlet or terminal valves should be of a type that will be positive in their action and yet provide delicate adjustment in order to regulate properly the flow of oxygen to patient. The terminal valves are of a stainless steel stem working against a bronze seat; they are of the needle valve style and should last indefinitely in ordinary service.

Caps to cover the valve outlet are held by means of a chain and are firmly tightened in place when the outlet is not in use by means of a small wrench attached to each humidifying outfit. This is to protect the threads on the outlet to which the humidifier is attached and also to prevent loss of oxygen should curious patients or visitors tamper with the valve.

Enough to Meet all Demands

It was decided that the number of outlets should be sufficient to meet any possible demand for oxygen therapy. All postoperative rooms are adequately supplied with outlets. All single and double rooms are served and every large ward has outlets to serve at least four patients at one time. The humidifiers are the Iowa model with flow meter attached, as designed by Dr. Stuart C. Cullen, chief anesthetist at the State University of Iowa Hospitals. These humidifiers are positive in their action, inexpensive as to their initial cost and easy and inexpensive to maintain. The humidifier is fastened directly to the terminal valve and for this setup no special pressure-reducing arrangement is at all necessary at the bedside.

Experience showed that a probable maximum of 30 patients receiving oxygen therapy at one time should be anticipated; therefore, this number of humidifiers was purchased, any one of which may be used on any of the 327 outlets in the system. The system as a whole is divided into sections, one section being determined by the architectural arrangement, *i.e.* a floor or a subdivision of this floor, such as a wing or ward. This enables any one of these sec-

tions to be taken out of service should it ever be desirable to do so.

The main pipe carries to a distance of about 200 feet underground outside the hospital where the supply unit is maintained. This is known as the "cascade" unit and has a capacity equal to approximately 185 "K" cylinders or 46,000 cubic feet of oxygen at 2200 pounds' pressure, 70°F. The unit is stationary and is charged with oxygen from a delivery truck whenever required. This truck transports the oxygen in liquid form and converts it to a gas before pumping it into the cascade unit. One gallon of liquid equals approximately 840 gallons of oxygen. This process is perfectly safe and attended by no annoying disturbances and requires only about one hour to deliver approximately 25,000 cubic feet of oxygen.

Before the cascade storage unit was attached to the piping system, the piping passed a twenty-four hour standing test of 200 pounds p.s.i. without loss of pressure. In order to make doubly sure, this test was continued for a period of seventy-two hours. The cascade unit was then connected and all air was blown out of the piping system with the oxygen by opening all outlets for a short period of time.

The cascade storage unit is composed of 12 tubes, each tube weighing approximately 2800 pounds, and is approximately 40 feet in length. Eleven tubes are used to serve the system, one tube being kept in reserve to be used only when the other 11 are being filled. The cascade unit has a panel which provides a dual system of controls and safety valves. It is here that the pressure is reduced to 50 pounds p.s.i., which is the line pressure at the outlets within the hospital. The cascade storage unit remains the property of the oxygen vendor who is responsible for its maintenance.

One tube has a thermometer well sunk into one end and this records the temperature of the oxygen within the tubes. This temperature plus the pressure reading enables us to make a computation of the quantity of oxygen in the tubes at any given time. Therefore, in order to determine the quantity of oxygen delivered, pressure and temperature are recorded immediately before and after the fill. This enables a calculation of the quantity within the tubes

from each of these readings and the difference gives the amount delivered to the storage unit.

Proper formula and determination charts are supplied by the vendor company for this purpose. These readings are made by the trucker who delivers the oxygen and are checked by a representative of the hospital.

In discussing possible economies to be effected, these must, of necessity, be divided into direct and indirect savings. Direct savings are elimination of freight charges, as oxygen is now delivered f.o.b. cascade storage unit. There is also a considerable reduction in the cost of the oxygen itself. These direct savings would enable the hospital to amortize the cost of the piping system in slightly more than three years.

Saves Time and Manpower

Indirect savings, such as elimination of approximately thirty minutes of manpower in handling each cylinder, reducing maintenance cost by eliminating cylinder trucks and a large number of reducing valves, would increase the amount of savings appreciably. Also, the time required to begin oxygen therapy with the piping system is about half that required to connect a cylinder.

A factor to be considered is the possibility that more oxygen might be used because it is convenient and immediately available. However, this is offset somewhat by there being no loss of residual oxygen. Definite figures are not yet available on this point as the system was only placed in service on March 6, 1945.

All oxygen therapy is under the direct supervision of our anesthesia staff, which provides professional supervision and control. This arrangement is practical for two main reasons: first, someone is always available and, second, the anesthetists are thoroughly familiar with the physiologic aspects of oxygen therapy. All orders for therapy are communicated to that office and an anesthetist immediately begins therapy.

The humidifier units are given at least daily inspection by an anesthetist to assure their continued functioning in a proper manner. This method of control assures that the necessary equipment is kept in first-class order and also facilitates the maintenance of accurate records.

Supplies Flow Smoothly

With a Central Service

CENTRAL supply service as defined by Mills Memorial Hospital, San Mateo, Calif., means "bringing together in one department all articles of supplies and equipment having to do with the care or convenience of our patients." This covers a wide range of articles, such as dressing trays, cast carts, balkan frames, inhalators, compress kettles, portable telephones and radios.

Although planning for our central supply department began in 1936, it was not until April 1940 that we had it fully equipped and ready for operation. When our hospital was constructed, no provision had been made for such a service and the only available space was in the basement adjacent to the hospital pharmacy.

We were, however, fortunate in that we were able to construct an electric dumb-waiter running from the basement directly to all floors of the hospital. This electric dumb-waiter is accessible to both the central supply and the pharmacy and opens in a utility room on each floor of the hospital. We have a direct telephone service between each such utility room and both the central supply department and the pharmacy.

Best Equipment Available

We were also fortunate in that we established our central supply service when the best of equipment was available although we have made in our own shop considerable equipment, such as cast carts, stomach evacuator units and isolation units.

The procedure we are using in the operation of our central supply service has proved to be highly successful. The important feature of this service is that trays and equipment are completely assembled *before* they are called for. There is no time lost in collecting items needed on any tray after a requisition has reached the central supply room. It is only necessary to take the tray off the shelf or cabinet and send it up by the dumb-waiter. This makes the service so fast that a nurse can requisition and obtain the necessary equip-

ment while waiting at the dumb-waiter.

The first step we considered was to simplify and standardize to a reasonable level all existing routine procedures. The second was to develop an up-to-the-minute "procedure book." The procedure book contains a copy of all the established procedures, accurate to the last detail. We have also found it helpful to give a full list of equipment at the top of all procedure lists. After standardizing our procedures and developing our procedure book we determined the number and type of trays required, taking into account the following considerations:

1. That enough equipment should be provided for the major load of patients within the hospital.

2. That this equipment must be instantly available. Emphasis was placed on the fact that if trays are to be instantly available *enough* equipment must be on hand to meet all needs.

3. That everything needed for a procedure should be collected on a tray, the tray to be strapped and tied and the whole sterilized.

The only diversion from this rule of preparing the tray is that if an article cannot be routinely sterilized, it is added to the outside of the pack after sterilization but is placed inside the tie before the sterile pack is placed on the shelf in the cabinets. When a tray is ordered it is always ready for immediate delivery. This particular plan is, we believe, the basis of our success with our central supply service.

Enough trays or sets of equipment for a definite procedure must be ready to meet all reasonable needs. This means that should the usual needs of the hospital be 20 catheteri-

zation trays a day, the full 20 sets of equipment must be ready for that purpose and that purpose alone. There is no borrowing from one tray to complete another.

All central supply equipment, trays and supplies are issued only on signed requisitions. Requisitions are made on the floors in triplicate and all three copies are sent to central supply.

Distribution of Requisitions

One copy of the requisition is sent back with the tray and is filed in a card index on the floor beside the dumb-waiter; one copy is placed in a file in the central supply department under room or ward number, and one copy is placed in a file in the central supply department under type of equipment and tray.

The use and the value of these copies are as follows:

1. The copy sent to the floor is returned with the equipment to the central supply room. This saves time for floor nurses and for central supply in showing exactly where the tray came from.

2. The copy filed under room number is for general information in central supply. All equipment issued to a patient can quickly be checked.

3. The copy filed under equipment is also for central supply information. If some type of equipment is running low it is possible to check the location of all sets in a moment and determine whether it might be possible to have some returned.

All copies of requisitions are removed from the files when the equipment is returned to the department. We believe that an adequate requisition system is of the utmost importance to the smooth running of

WILBER L. KRELL

Superintendent
Mills Memorial Hospital, San Mateo, Calif.

Rules and Procedures for the Central Supply Department

Care of Equipment

1. *Stainless steel.* Wipe off with cleaning solvent (benzine base) and polish.

2. *Needles.* Immerse in green soap and wipe out hub with applicator; rinse in water, then acetone. Dry with compressed air. Examine all needles for bluntness and roughness at this time and sharpen as necessary.

3. *Rubber sheets.* Cleanse with disinfectant, rinse with water and hang to dry. Place rubber, materials for discard in special container, not in waste receptacle.

4. *Arm boards.* Cleanse with disinfectant and water and dry.

5. *Glassware.* Immerse any cloudy or discolored glassware in special solutions. When received from pharmacy or storeroom, cleanse and dry before putting away. Place discarded or broken glass in separate container.

6. *Suction sets.* Wash bottles thoroughly, then boil. Submerge tubing in a 2 per cent solution of formalin with sodium bicarbonate, rinse thoroughly, boil three minutes or autoclave if returned from infectious case.

7. *Electrical equipment.* Coil cords of electric pads on top of pad. Wipe electric plates with cleaning solvent then machine oil. Test electric suction apparatus for functioning before sending out.

8. *Syringes, Luer's.* Cleanse with tap water and acetone. Verify number of barrel and plunger, making certain they correspond. Specify syringes as to ounce capacity on outside of wrapper.

9. *Intravenous and subcutaneous tubing.* Soak in basin tap water; cleanse inner wall thoroughly with running water from faucet spigots for at least one hour, followed by distilled water. Dry with compressed air and powder outer wall. Test tube for resiliency at this time.

Transfusion sets for blood and plasma. Disassemble filter drip and cleanse thoroughly in tap water. If all particles do not wash from stainless steel screen, soak in nitric acid until dissolved. Reassemble filter drip and tubing. Soak all equipment in basin of tap water. Clean inner wall of tubing thoroughly by running water from faucet spigots for at least one hour followed by distilled water. Then run 100 cc. of 2½ per cent sodium citrate through filter drip and tubing, making certain that all inner parts of glass and tubing are thoroughly treated with this solution. This is very important. Dry with compressed air. Slightly loosen filter cap. Autoclaving will not harm action of sodium citrate.

New I.V. tubing. Treat to render sulphur-

and acid-free. Only pure gum rubber can be treated in the following manner. With a large irrigating can circulate a boiling hot solution of 2 per cent sodium hydroxide through the tubing. Let remain in the basin of solution for forty-five minutes. Repeat the same process with a 1 per cent solution of acetic acid. Then circulate slowly running tap water through the tubing over night. Follow by distilled water and compressed air through tubing.

10. *Catheters.* Rinse catheters from trays before rewiring.

11. *Enema tubes.* Place in 2 per cent formalin solution to remove odor. Wash thoroughly and boil three minutes.

12. *Autoclave.* Brush floor out each morning; clean screen vent with metal brush. Oil floor and walls once a week.

13. *Surgical blades and suture needles.* Apply lubricating oil and leave on before autoclaving.

14. *Thoracentesis pump.* Do not autoclave or submerge in solution. Clean by wiping with disinfectant.

15. *Tourniquets for I.V. sets.* Do not powder. Rinse with tap water and hang to dry.

16. *Oxygen masks and tubing.* Submerge in 2 per cent phenol for half an hour. Rinse thoroughly and wrap in towel when put away.

17. *Solution bottles on dressing trays.* Cleanse with acid alcohol when returned from floors. Cleanse tr. benzoin and tr. merthiolate corks with acid alcohol.

18. *Felt and rope.* Remove from splints, send to laundry and reuse.

19. *Splints.* Autoclave those that will tolerate it when returned from use. Oil all screws.

20. *Spinal needles.* Sharpen with stylet inserted.

21. *Fracture bed.* Engineer should cleanse bed with disinfectant and oil when returned. Write a return on autographic register slip.

22. *Temperature recordings.* Keep recordings for autoclave for one year and then return to storeroom.

23. *Glycerine.* Use as lubricant for gavage, lavage and suction tubing. Do not use mineral oil. Staff order.

24. *Rubber tubing.* Powder all subcutaneous, blood filter, intravenous, douche, single catheters (not those on catheter trays), rubber drainage tubing, rubber dam. Also use powder on all rubber tubing with throat irrigating sets, irrigating cans, Kelly bottle and rubber aprons. Do not powder any tubing that is used intranasally or orally.

25. *Isolation unit.* Wash basins, wastebasket, soap container and stand in disinfectant solution. Autoclave basins; put clean soap and paper towels in containers. Cover basins and wastebasket with clean checked towels. Wrap each gown, mask and cap separately in paper. (This is to keep them clean, not to be sterilized.)

Sterilization

1. *Cultures.* Take culture every two months.

2. *Shelf supplies.* Autoclave every three weeks on Sunday. After the initial sterilization the following articles need not be redone: stomach evacuators, gavage and lavage sets, perineal and douche trays, throat irrigating sets and rectal examination tray.

3. *Baby linen.* Autoclave twenty minutes at 250-260° F.*

4. *Quart and gallon bottles of solutions.* Autoclave thirty minutes at 250° F.

5. *Novocaine and nupercaine.* Autoclave nine minutes at 250° F.

6. *Cocaine.* Do not sterilize.

7. *Talcum powder.* Autoclave three hours at 250° F. before placing in cans or envelopes. It may be done for one hour three consecutive times.

8. *Iodoform solution.* Autoclave for twenty minutes at 250° F.

9. *Catgut.* Wash with soap and water, rinse and place in cyanide of mercury 1:1000. Allow to stand twenty minutes. Cover tubes in jars with gauze sponge.

10. *Infusion thermometers.* Immerse in cyanide of mercury 1:1000 for thirty minutes. Rinse with sterile distilled water.

11. *Sea sponges.* Boil three to five minutes. Watch carefully.

12. *Surgical dressings and parawax.* Immerse in bichloride of mercury and rinse with sterile distilled water.

13. *Suture needles and surgical blades.* Keep in tr. merthiolate solution.

*Standard practice is to autoclave for ten to fifteen minutes at 25° F. maximum temperature.—Ed.

Solutions

(Solutions prepared in central supply department are to be dated on bottle.)

1. *Oxalic acid.* Removes potassium permanganate from equipment.

both the central supply service and the floors.

All trays and other pieces of equipment are numbered and this number is placed on all three copies of the requisition. This makes an excellent follow-through system for, should anything be missing or broken, information is available as to the name of the patient, room number, tray number and the nurse who used it.

For further convenience, during personnel turnover, each tray and set carries a list of pieces of equipment belonging to the set. We have tried

several methods for these labels and have found typewritten adhesive plaster the most satisfactory. These labels can be sterilized several times without being changed and are inexpensive.

For more elaborate sets, such as blood transfusions, we use a typewritten list encased in discarded, washed x-ray films. For sets that do not go through the autoclave the adhesive labels are painted with shellac. They can be cleansed dozens of times before changing is necessary.

Return of Equipment. All equip-

ment is returned cleansed, but sterilization and cleansing have been developed with two points in view: complete cleansing and safeguarding of equipment.

Charges. When any charge is to be made for any equipment or supplies used such charge is made at time of issue.

Special Dressings and Other Equipment. Items for patients that are not routine and that are likely to be needed frequently, for instance dressings in burn cases, are reported to central supply and special packs

Mills Memorial Hospital, San Mateo, Calif.

2. *Cleaning solvent.* Removes adhesive (obtain from engineer).

3. *Acid alcohol.* Removes merthiolate, mercurchrome and tr. benzoin. Do not use on any painted surface.

4. *Cocaine 10 per cent.* Send with: tonsil hemorrhage, antrum treatment and epistaxis trays when requested by the physician.

5. *Glass cleaning solvent.* (Potassium dichromate, technical, 100 mgm., concentrated sulphuric acid 250 cc., water 750 cc.). Obtain from pharmacy.

6. *Scale remover.* Use 1:4000 to clean sterilizer, compress kettles and inhalators.

7. *Distilled water.* Filter flasks of 250 cc. and 1000 cc. twice before sterilizing.

8. *Olive oil.* Use as lubricant for gavage, lavage and suction tubes. Do not use mineral oil. Staff order.

9. *Cyanide of mercury.* Make 1:1000 solution with one 7½ gr. tablet with 15 grains sodium borate dissolved in 500 cc. water and allowed to stand for twenty minutes. Use for catgut, lifting forceps.

10. *I.V. solution.* No refund given if blue seal has been broken.

11. *Normal saline, saturated boric and distilled water.* Keep sterile 1 gallon bottles of each on each floor and replace from central supply department when necessary.

12. *Novocaine for maternity.* Keep unsterile solution in cabinet L. Sterilize and send to the floor upon order by the department. Call the head nurse immediately when it is on the dumb-waiter and ready for use.

Miscellaneous Orders

1. *2 cc., 5 cc. and insulin Luer syringes.* Keep on each division and replace with sterile ones from C. S. when necessary.

2. *Night supplies.* Send one preparation and one enema tray to each floor at 8:30 p.m. These are for night emergency use and should be returned complete each morning.

3. *Work basket.* Send with: lumbar puncture, thoracentesis, paracentesis, aspiration, suture, pneumothorax and tracheotomy trays.

4. *Vaseline.* For gauze strips combine with 10 per cent paraffin. Obtain from pharmacy. Place vaseline cups and gauze on trays when sterilizing.

5. *Crutches.* Tag with length of crutch and when a pair is sold decrease the number on hand and reorder if necessary. Notify office when a pair is returned from the floors or outside. Sell arm cushions and tips separately; no refund on them. No refund on canes.

6. *Gowns.* Mark gowns from the linen room with the letter L or S designating whether long or short sleeves.

7. *Bed boards.* Note size when issuing as ward beds are 36 inches wide and private room beds are 42 inches wide.

8. *Scale remover in sterilizer.* Leave in over night. Label sterilizer.

9. *Balkan frames.* Write a returned slip on autographic register when frame is returned from patient.

10. *Pitchers.* Cover pitchers for sterilization with a towel secured by a safety pin.

11. *Compress blankets.* Cut in eight pieces.

12. *Oxygen.* Put through charges when tank is issued. Test for poundage before sending out, and on the slip place the number of the tank and the number of pounds it contains. Charge for use of the equipment at the end of the week. Place tanks on carriers or strap to the patient's bed when in the room. Always chain extra tanks in supply room.

13. *Telephones.* Do not issue unless O.K.'d by attending physician and superintendent. Inform operator of patient's name and room number. Write a returned slip on autographic register when returned from patient.

14. *Radios.* Do not issue to double rooms or wards unless authorized by superintendent. Specify on autographic register sheet when discontinued.

15. *Dressings and supplies.* Do not sell to out-patients.

16. *Maintenance.* Superintendent must O.K. work to be done by chief engineer or painter.

17. *Specimen bottles.* Cover bottles on catheter trays with cap and paper.

18. *Walking heels.* Obtain from surgery.

19. *Carrier cart shelves.* Designate by signs whether sterile or unsterile.

20. *Small pillows.* Issue only rubber covered pillows to maternity patients.

21. *Sterile sponges.* Identify 3 by 3 sponges by white string on lid; 4 by 4 sponges by blue string on lid; towels by red string on lid.

22. *Benzene rags.* Discard in waste.

23. *Autographic register.* In case of error, mark void but in no case destroy the sheet. Keep the third duplicate slip in supply room for three months.

24. *Sterile supplies.* Always remove supplies in closets and on shelves from the right and put in from the left, so that they will be rotated and will not become unsterile by standing.

25. *Splints.* Charge a deposit and refund when they are returned. Rental is not charged while the patient is in the hospital.

26. *Equipment and supplies.* Note equipment and supplies that are charged by a pencil check on the requisition at the time the charge is made.

27. *Soda line (dioxorb.) for oxygen tents (4-8 mesh).* Change when the granules become yellow. This is the responsibility of the attending floor nurse.

28. *Transfers and dismissals.* Obtain from the office each evening. Change transfer slips in the files and check dismissals for unreturned equipment; notify floors of missing articles.

29. *Numbers.* Note numbers of all marked supplies on all three slips when the requisition is filed.

30. *Oxygen tanks and Thomas splints.* Check each morning.

31. *Equipment.* Enter equipment sent out to be repaired or replaced in the repair book with number of article, date sent, date returned and whether repaired or replaced. Do not interchange equipment between departments.

32. *Gloves.* Obtain unsterile supply from surgery. Used gloves are not returned to supply room, but to surgery by nurse on floor.

33. *Electric pads.* Send new pads directly to engine room to be regulated for heat control. Do not issue any unless the attending physician's O.K. is designated on all three requisitions. Put in flannel cover before issuing.

34. *Bandage.* Tear selvage edges from muslin and flannel bandage. Remove three threads from each side of crinoline after it is torn. Make bandages five yards long.

35. *Asbestos pads.* Issue with electric plates.

36. *Crutches.* Sell only in pairs.

37. *Oxygen tanks G size.* Write "O₂ 99.5 per cent" on tank with red pencil.

Requisitions

1. *Patients charges.* Separate according to date and staple together each evening. These are kept in C. S. for three months.

2. *Pharmacy.* Make out in duplicate.

3. *Linen room.* Obtain O.K. from director of nurses or superintendent.

4. *Engineer and storeroom.* Obtain O.K. from superintendent.

The last named requisitions fall under three groups: Those for use in C. S. only, such as soap, pencils and autographic register tags; those ordered out of stock, such as canes and instruments, and those stocked in storeroom, such as syringes and gauze.

are made and sent to the floors ready for service.

We have an alphabetical list of all equipment and supplies that are issued by the central supply department, such list being kept in a college binder, showing the article, the number or amount available, the location and the price. To illustrate: dressing trays are listed as follows:

Item	No.	Location	Price
Dressing Trays	24	Cabinet J	\$0.75

Accompanying this article is a copy of our rules and procedures.

In addition to our alphabetical list of all equipment and supplies, we also have a 4 by 6 inch alphabetical card index file of all trays available in the central supply department. Each card gives the name of the tray, the number, the location and charge, if any, as well as a complete list of all of the articles that comprise the tray.

A number of special dressing and other trays have been set up at the request of various members of the medical staff to meet their requirements and for their individual use.

Credit for assisting in the original planning and the degree of success which we obtained in establishing our central supply service must be given to our director of nurses, Florence M. Taylor. The successful operation of any central supply service depends to a large extent upon its personnel and particularly upon the supervisor. We again have been fortunate in having an especially qualified, loyal central supply supervisor to whom belongs all credit for having, in our opinion, one of the best central supply units.

These Administrative Axioms

Take the Long-Term View

E. M. BLUESTONE, M.D.

Director
Montefiore Hospital, New York City

IN OUR search for an improved terminology in the field of hospital care, the "chronic" patient has very properly become the "long-term patient." We can, however, do still better with the new "Department for the Care of Long-Term Patients" which will characterize the hospital of the future by naming it the "Department for Continued Care." This will mean continued medical care, no matter what the circumstances, and will embrace the whole area of follow-up and rehabilitation.

THE PREVENTION of malpractice is the greatest single task of the hospital executive. The more you reflect on such an assignment the greater appears the opportunity.

WE ARE ON the threshold of great events in the evolution of our establishments for the sick and these do, indeed, require a profound change in our professional attitudes toward them.

THE PHILANTHROPIST, the scientist and the social worker are noted for their ability to see beyond their own noses; why, then, is the long-term patient in the blind spot of their vision?

THE WORD "psychosomatic" is one word and not two words, nor is it hyphenated. You cannot separate the psychiatric from the somatic aspects of medical care.

ACUTE ILLNESS in the hospital may be short term or long term. As time passes, and the easier problems in medical science are replaced by the more difficult ones, we shall find that we would be wise in our planning if we would gear our hospitals to the scientific needs of the complicated long-term medical problems (which could easily embrace the less complicated short-term problems) rather than the other way round by which the short-term patient is favored while the long-term patient is neglected.

THOSE WHO persist in believing that long-term patients are best cared for in independent chronic disease hospitals, located on the periphery or beyond, lean heavily and optimistically on the belief that they can do away with the indecencies and inhuman neglect of the almshouses, poorfarms, homes for "incurables" and the like. They plan to modernize and humanize these facilities while adding to their number, in order that scientific care may be given the long-term patient at a time when he needs it most. These planners are, in effect, establishing the hospital of the future in the wrong location, assuming that they can command the comprehensive services of medical science at such distances. It will follow, as the day the night, that such hospitals, except for location, will be found to be ideally suited for short-term patients, too. Why, then, do we not look ahead and plan correctly, from the start, for all patients, without exception, under an integrated plan in which the doctor is close enough to study the natural history of disease in all of its phases, from infancy to old age, in a group of well-located buildings physically set apart but socially unified?

WHEN MEDICAL science will come to grips with the problem of aging, it will be undertaking the last great battle of its long, honorable and successful career in human history.

"PEAK LOADS" are more frequent and more challenging to our ingenuity as hospital executives in the "acute" than in the "chronic" hospitals. In any case, an adequate reserve of beds should always be budgeted in our planning.

THE PRINCIPLE of prevention can never safely be absent from the mind of the hospital executive in his planning. Indeed, he pays homage to

this principle when he insists on personal and public hygiene and on hospital sanitation in all of its applications. He knows the great accomplishments of preventive medicine and how it has revolutionized our social and medical care programs, but he will have to dig deeper and consciously ask himself how well, and how thoroughly, his hospital prevents (a) complications, (b) sequelae, (c) chronicity (and dependency), (d) relapses and (e) fatal outcomes.

IT ISN'T age that one need fear. It is the infirmity that often goes with age.

THE EFFICIENCY and inexorability of the biological law of the survival of the fittest can be reduced by the conscientious hospital executive.

ACQUIRED characteristics (in the house staff) are not transmitted.

"MISERY likes company" is a perverted form of the gregarious instinct in hospital wards.

GROUP MEDICINE is already being practiced in the hospital when the consultation index is high.

A WARNING to hospital executives: Never mislead a philanthropist by permitting any kind of waste with his contribution.

THE TEST of a good ophthalmologist is his knowledge of the inner recesses of the eye, including the optic nerve. The test of a good otologist is his knowledge of the inner ear, including the auditory nerve. Neurology and ophthalmology overlap and so do neurology and otology—additional illustrations of the interdependence of the specialties and of the need for treating the total patient by total methods.

WHAT the hospital has *not* done for the patient and what the hospital *has* done for him must be of equal interest to the social worker, and therefore to the hospital executive.

EVERY BED in every hospital, no matter where it is located, whether it is private, semiprivate or ward, is potentially a teaching bed and potentially a research bed.

OUR HOSPITALS will fulfill their destiny when every member of the attending staff is treated as a man of science rather than as a practitioner of medicine.

EDUCATION

IS OUR First Concern

ALAN GREGG, M.D.

Director, Division of Medical Sciences
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I HAVE visited a great many hospitals in a great many countries, looked at the patients and talked with the doctors (and sometimes, in the interests of realism, wished I might have talked with the patients and looked at the doctors), watched the nurses and orderlies at work and asked to see the patients' records—all in all a wide variety, from Manitoba eastward to Sofia and Lenin-grad westward to Canton.

Hospital work can pivot about one or another dominating principle. In one case the determining factor appears to be religious piety (or its degeneration product, sectarian zeal). In another case the organizing principle and final arbiter prove to be seniority of service. Military rank and discipline, or nostalgic imitations thereof, provide the cardinal point around which the affairs of many an institution revolve. And not infrequently hospitals are run on what for lack of a better term must be called the prestige principle—staff appointments going to physicians of fashion and local prestige, and control going to the rather more sober elements of high society or aspirants thereto.

When the Wheels Turn Smoothly

However, neither piety, nor seniority, nor military rank nor prestige provides as sound a pivot for hospital work as the kind of interest and activity we describe by the word education. When the criterion for appointment is the capacity to teach or to learn and the yardstick for self-evaluation is how much are we really learning and teaching, our hospital runs like a well-centered and well-oiled wheel—truly and well. A few remarks on education in our hospitals may therefore justify a moment's reading and an hour's reflection.

The word "education," though often implying all the machinery of instruction, does not depend on it. Education takes place between two people when one or both want it to take place. Education does not de-

pend on lectures, recitations, courses, credits, examinations and diplomas. It does depend on contact between persons who want to learn or teach. Review your own past in search of the turning points in your growing up and you will get a fresh view of the vital part of education. The study and care of the sick, the wards, the laboratories and certainly the corridors of a hospital provide limitless occasions for exchange among those who want to learn or teach.

Indeed, I do not see a rosy future for any hospital—especially the small voluntary hospital—unless it takes teaching as the reference point for all its efforts—not piety, or seniority, or rank or prestige—but concern as to how much the patients, the attendants, the nurses, the doctors, the administrators and the trustees are learning today that they didn't know yesterday. We are not in the year 1875. This is 1945 and there is so much more to learn about disease now that education must be a major concern of the hospital.

Education would have dubious claim if it were to exclude other objectives and responsibilities of hospital work. It does not exclude them. It includes them and moreover puts them in orderly and harmonious relationship while doing so. As long as nurses can feel at the end of each week that they have "learned a lot" they will not resent their training as a form of exploitation. In hospitals where interns receive intensive effective teaching and guidance they work hard and demand little. The administrator with an honest desire to learn and, if necessary, to change in order to learn has an advantage

over the man who mistakes inertia for firmness and routine for order. The trustee who wants to know, who wants to learn, becomes steadily more trustworthy and valuable.

However, the chief gainer when the hospital becomes a teaching hospital is the patient. If these brief paragraphs convey nothing else, I would want them to convey just this: teaching is the greatest service and safeguard to the patient that the hospital can provide. If a doctor or resident or head nurse or administrator is going to use a case for teaching or investigation, the history is taken better, the laboratory work is more carefully selected and more closely checked, the physical examination is more detailed and meticulous and the treatment is more exactly determined and more attentively supervised. Whoever demonstrates a case will go over it with extra care. We human beings don't like to make fools of ourselves—especially in public—and persons chosen to lead do not enjoy failure or ridicule. Valuable as teaching may be for teacher and pupil it is of superlative value to the patient.

Help the "Lost Generation"

One more reason for regarding education as the hospital's great concern in these times: Soon we shall have returning from the war fifteen or twenty thousand doctors. Most of them will be the younger men who had hurried training in understaffed schools and hospitals, and all have been long separated from civilian practice. Medically, it will be a lost generation unless our hospitals provide teaching and experience under competent guidance to a degree never approached in the past. A bad internship is worse than no internship at all; the quality depends on good teaching and supervision. The medical schools cannot possibly absorb the number of doctors returning from the war, the best of whom will apply, and already are inquiring, for internships, residencies, refresher courses, junior posts—any experience that will help them learn what they need to enter into civilian practice.

From "Convention by Mail" of the New England Hospital Assembly, April 1945.

A few suggestions: the Army and Navy should give priority in demobilization to doctors who have teaching posts assured them. Otherwise frustration awaits the men who seek training on their return. By any means at hand, including the most drastic, hospitals should find adequate salaries for competent teachers on half or full time to supervise as large a staff of interns and residents as can be accepted. Affiliation with medical schools even at a distance should be sought and insisted upon and maintained in behalf of the education of doctors returning from the war hungry to learn. A hospital that has been paying a total of \$5000 a year to a staff of eight interns

would do well to use the money as a salary to a competent teacher . . . for where there is good teaching in the next five years there will be younger doctors eager for such an opportunity—and of quality superior to the usual intern who insisted on a salary because the experience was worth so little.

Every hospital trustee and executive must now examine his institution soon in the light of its teaching function. As Paul Bourget observed: "You must live as you think, if not, sooner or later you will finish by thinking as you have lived"—and who wants to spend the next ten years in excuses, alibis and recriminations?

The Staff Is "Sold" on this **Premature Nursery**

GEORGE D. SHEATS

Administrator, Baptist Memorial Hospital, Memphis, Tenn.

OWING to the increasing demand for premature infant care Baptist Memorial Hospital, Memphis, Tenn., has put into operation a premature nursery which meets every need and is still simple in its application and construction.

In order to avoid the orthodox method of individual incubator oxygen therapy we decided that if we designed this unit so that the individual incubators would be supplied from one central oxygen supply, it would obviate the necessity

for frequent tank changes and provide a more accurate measurement of oxygen to each incubator.

First, an incubator was selected that meets all underwriters' requirements for oxygen therapy, is fool-proof and easily portable. A battery of six of these incubators was installed and connected to an oxygen supply line, each incubator having a separate flow meter to regulate the oxygen in liters. The cylinder or source of this supply of oxygen carries a pressure up to 2200 pounds;

therefore, it was necessary that a pressure-reducing valve be used to maintain a constant lowered pressure in the distributing line.

The two oxygen tanks that supply these incubators are connected with a high-pressure manifold so constructed that it is possible to withdraw gas from either one or both tanks at one time. By closing the proper valve on the twin tank's connection it is possible to disconnect that tank while the other one is open to the line and in this way remove an empty tank and replace it with a full one without shutting down the system.

With the regulator attached to the outlet of the twin tank's connection only one regulator is required for the two cylinders. Where the demand is such that a frequent changing of tanks is necessary the manifold could be used, taking five or 10 cylinders. This would not be necessary, however, unless a larger number of incubators were connected to this supply.

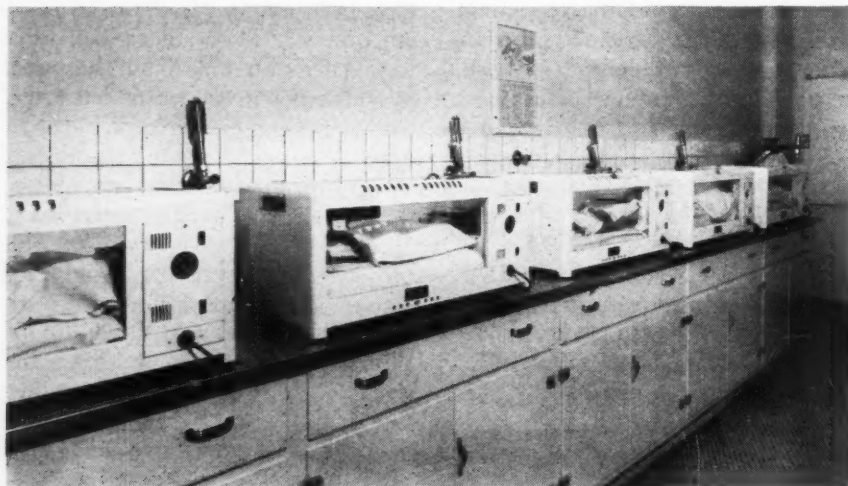
In addition to these six incubators so connected, there are two units that are portable and are used for the isolation of out-patient infants until they can be placed in the regular premature nursery. These two units can be connected to these oxygen lines whenever necessary.

In addition to oxygen connections to these incubators there is located between each two incubators a vacuum connection for purposes of aspiration. A positive air connection is also included in this setup.

Located beneath each incubator are all the necessary equipment and clothing for the care of each infant. This nursery is isolated by a vestibule in which are placed all gowns and masks for the attending physicians and nurses. A window is provided in the end of this room for the showing of these babies at scheduled times. This can be accomplished even though they are receiving oxygen therapy constantly.

This unit has proved extremely popular and we are receiving prematures for incubator care that are being delivered outside of the city. We charge \$1.50 per day for the care of premature infants in this nursery.

We have been highly gratified with the reception that this unit has received from our entire staff and the obstetricians whose work is done in this institution.



Convalescent Home

The Bridge Between

Hospital and Health

HARRY HYMAN

Superintendent
Resthaven for Convalescents
Broomall, Pa.

FAR down on the list of health institutions, in the opinion of both the public and the medical profession, stands the convalescent home, somewhat like a poor relation. Yet the still untouched potentialities of such a service are greater than most of us realize, and properly administered homes are of inestimable value not only in completing the cure but in preventing a recurrence of illness.

The patient about to be discharged from the hospital is often unfortunate: hospital space today is badly needed for more active cases, most hospitals lack facilities for the recuperating patient and, usually, he knows of no reliable convalescent home to which he can go to complete his cure and effect the necessary adjustment to fully normal life. So he goes home, where, as is often the case today, with most families either broken up or working at their war jobs, it is not possible for him to obtain the care and attention he should have. Even in those homes that are not affected by the war, it is not always practicable to arrange special diet, therapy and routine.

It is with these cases that the convalescent home is primarily concerned, yet few homes are equipped to handle them. The blame for this may be laid to state licensing laws and, in turn, to convalescent homes themselves. Such institutions have been in existence for only the last twenty-five or thirty years, hence are still too new to have merited uniform laws and licensing requirements.

The Lady Means Well

In many states no license is necessary and no standards have been set up, so we find the home run by a nice elderly lady who has a kind heart, but not much else. She started out as a nurse, and when her best friend became ill, she took her in and cared for her. Pretty soon another friend came to her; she turned her dining room into a bedroom and marketed for three instead of for one. Neither the lady nor the home was really fit for the task.

Our first need, then, is for definite and rigid standards, to be determined and administered by the states just as state medical laws are deter-

mined and administered. Hand in hand with these rules and regulations should go some sort of organization among the superintendents of these homes, where problems of administration and care could be discussed and experiences and ideas could be exchanged for the benefit of all. (A later article will deal in detail with the possible setup of such an organization.)

Let's return for a moment to the kind-hearted lady. She not only had to use her dining room as a bedroom but, as more people came to her, was obliged to use her living room as well. Naturally, the home did not have sufficient sleeping, kitchen or bathroom facilities and it had no provisions whatsoever for the various types of therapy and recreation necessary to complete recovery.

This condition is found frequently in the privately run home and it is a large part of the reason for its insufficiency in meeting the problem. Too often, the convalescent home is merely a private home converted to its new use, improperly laid out for this use and run by day workers instead of by a qualified regular staff.

Our next requisite, then, is to find the proper location, build the right home and staff it expertly. It should be located away from congested areas but easily accessible by the ordinary means of transportation. The grounds should be well tended, no matter how simple and plain their appearance. Where there is space for it, a swimming pool, such as is found at Resthaven, Broomall, Pa., is an attractive feature.

It is not necessarily the function of the general hospital to provide a comfortable, homelike atmosphere, but the alert administrator will see to it that his convalescent home is a comfortable and cheering place to be in; such a background gives the patient and his family confidence

and helps assure the patient that his personal problems will be handled with kindness and diplomacy.

The home should be large enough to accommodate at least the minimum facilities and equipment. These include a completely equipped and modern kitchen and diet department, an infirmary, a recreation room, physical therapy room and occupational therapy department. The infirmary should contain a complete supply of various stimulants and provisions for oxygen therapy. This room should be located at a point convenient to an exit, so that in the event of the patient's death, or his being removed to a hospital, he will not be near other patients.

The physical therapy room should contain short-wave diathermy machines, a whirlpool bath and other types of equipment necessary for treating the particular kind of patient with whom the home is primarily concerned. It should also house a walker, exercisers and the milder kind of gymnasium apparatus.

Should Provide Entertainment

In the recreation room we should find a radio, good magazines and books, a piano, if possible, newspapers and a variety of games. Along this line we might add that entertaining and informative movies on health subjects are available from the Metropolitan Life Insurance Company and other groups.

The occupational therapy room should house various pieces of equipment that aid the patient in regaining confidence in himself and the healthful use of the body muscles.

The kitchen is the most important department in a convalescent home.

Like the kitchen in a hotel, it indicates the character of the entire institution. Since convalescent homes tend to treat by age rather than by disease, it is necessary to arrange separate diet controls for young and old patients. We can also note, in passing, that the needs of young and old patients differ greatly, not only as regards diet but also as regards occupational therapy, physical therapy and recreation.

If the building is two stories high, use should be made of ramps wherever possible, because of their ease of use and absence of mechanical parts that may get out of order.

In the construction of the building itself, we should find floors of linoleum, terra cotta or asphalt tile but not wood, since wood is highly absorbent and will eventually create insanitary conditions.

The walls should be covered with fabric, paint or plaster—not paper. At least one door to the home should be wide enough to admit a bed. The entire home itself should be as clean and well ordered as a hospital.

Because patients are ambulatory, good bathroom facilities are of even greater importance here than in the hospital. Communicating bathrooms between rooms is the minimum

requisite, but a private bath for each room is far more desirable.

In addition to the information furnished by the patient's physician, such tests as urinalysis and a blood count should be made upon the patient's admittance to the home.

The difference between the successful, long-lived convalescent home and one that is forced to close after an existence of two or three years may sometimes be traced directly to the superintendent or administrator. It is his task not only to supervise therapeutic and recreational treatment and to direct his staff efficiently but also to be available to his patients whenever they need, or think they need, his help. He must be ready to listen sympathetically and with genuine interest to his patients' problems; he must make himself available for consultation with the families of convalescents; he should group patients according to congeniality, whenever practicable, and at all times he must be diplomacy itself, for human relationships in his convalescent home are far more personal than they are in the hospital and must be maintained in the pleasantest manner possible.

To carry out such a program as has been outlined here, it is obvious that the rates charged must be commensurate with the services given. We do not expect the hospital to give first-class service at an unreasonably low cost but we do often expect this of the private convalescent home. Unless such a home is true to its name and actually does aid in the patient's final recovery it has no value, and an investigation of low-cost, small homes will show that, generally speaking, they do not provide even the minimum in facilities and treatment.

A public educated and aroused to the benefits obtainable through proper convalescent care will be willing to pay the price of that care, once its reasonableness has been made apparent.

An intelligently planned, energetic organization of home superintendents, working hand in hand with hospitals and county and state medical societies, can educate the public to the need for and value, both psychological and physical, of correct convalescent care and, in so doing, will inevitably heighten the dignity and prestige of convalescent homes throughout the country.

Plasma Bank Is Possible

in the Small Hospital

MARION McCLURG, R.N.

Supervisor
Greenville Hospital, Greenville, Pa.

THE extensive interest in the use of plasma occasioned by World War II induced the staff of Greenville Hospital, Greenville, Pa., to investigate the feasibility of establishing a plasma bank in our small community hospital (50 beds). When complete information and costs had been assembled, the local lodge of B.P.O.E., which had long been interested in the development of our hospital, offered to sponsor the project both financially and by furnishing member blood donors to start the bank.

A small room close to the hospital operating rooms was fitted with plumbing and utensil storage facilities to be used exclusively as the plasma bank. The principal items of equipment purchased included a large high-speed centrifuge, a low-temperature storage unit and accessories for collecting, pooling and dispensing the plasma.

Our operating room supervisor went to the Elizabeth Steel Magee Hospital laboratory in Pittsburgh for instruction in the technic and procedure, and the bank has proved both a technical and hospital service unit success from the start.

As donors were typed and serology was checked, a permanent file of

types was made so that donors could be procured on short notice for whole blood transfusions. This index is maintained on all individuals typed for the bank so that an adequate number of all blood types is available.

Until recently, the red cells were discarded, but under the present system the plasma used is now replaced as a by-product as blood is taken to meet demands for red blood cells. The red blood cells are used in primary and secondary anemia cases for patients who have no need for plasma. Also, some red cells are made into red cell paste and used as reported in current literature on the subject.

Primary credit for the success of our plasma unit is due to the sponsorship of the Elk's Lodge of Greenville through whose cooperation we have a free donor system so that the only hospital charge for whole blood, plasma, red cell infusions and red cell paste is the laboratory fees for crossing and processing.

We are now adding Rh testing of all of our patients prior to transfusions and are also preparing to test our donor list so that Rh negative blood of all types will be available when needed.

California's Psychiatric Survey Spells Hope for the Mentally Ill

IN 1943, the California Department of Institutions, recognizing the present inadequacy of its setup for the care of the mentally sick, the epileptic and the feeble-minded, requested the United States Public Health Service to make a survey of the present facilities and make recommendations for improvement of the present facilities and a long-range building program. Dr. Samuel W. Hamilton was assigned by Dr. Thomas Parran, surgeon general of the U.S.P.H.S., to make a thorough study in September and October 1943.

At the time of the survey, there were 24,240 patients in the mental disease hospitals which had a normal capacity of only 20,558 so that there was an overcrowding of 17.9 per cent. The institutions for mental defectives had a resident population of 4728 with a normal capacity for 4038, thus having an overcrowding of 17.1 per cent. The best estimates indicated that in 1948 there will be 28,000 mentally ill and 8000 mental defectives in the state institutions, an increase of 7000.

Age Is Major Factor

California does not make as liberal provisions for its mentally ill as does Massachusetts, for example. If California were to provide as adequately as does Massachusetts, it would need more than 40,000 beds. Doctor Hamilton's report pointed out that the apparent increase in mental illness seems to come largely from the fact that more persons are living to be over 60 years of age and that the incidence of mental disease is much higher in such age groups. One paragraph dealing with this problem of the elderly person is worth quoting verbatim:

"There are those who declaim about this burden and assert that the younger members of families in which an elderly person has developed mental illness are somehow at

KARL M. BOWMAN, M.D.

Medical Superintendent
Langley Porter Clinic, San Francisco

fault for not keeping the old person at home. But for years we have been improving the treatment afforded in our hospitals and have been urging the community to get its patients to us early in their illness instead of clinging to them until the last possible moment. It would be absurd to throw all this sound reasoning overboard and now try to get families to keep their patients at home as long as possible. This is neither sound medicine nor sound social sense, nor is there objective evidence that family feeling and spirit of self-sacrifice among the young are less than they used to be. Since the dawn of time such complaints have been made by the older generation against the younger, and there is no demonstration that the complaint is any truer now than it was 4000 years ago."

The report emphasizes the need of increasing the medical personnel. As compared with such states as Massachusetts and New Jersey, California has a much higher patient load per authorized physician (301 patients per authorized physician in 1940 and 282 in 1943).

California has likewise had few trained nurses. The ratio of patients to graduate nurses throughout the United States is 94 to 1. California has a ratio of 1269.6 patients to each graduate nurse. Only two states in the Union have a higher ratio.

In studying the institutions for the mentally deficient, California ranked twenty-eighth among the 44 reporting states in the liberality of its provisions for the mentally deficient.

Most of Doctor Hamilton's recommendations are quoted in the panel on the following page.

In line with Doctor Hamilton's recommendations, the following pro-

gram has been advocated. The department of institutions, which in the past has had charge of the mentally sick, the feeble-minded, the epileptic, the blind and the corrective institutions for juveniles, has asked that its name be changed to the department of mental hygiene and that it function as such. The institutions for juvenile delinquents were taken away from it when the Youth Authority was formed in California. The department is now asking that the care of the blind be placed under the department of education, leaving it the care of the mentally sick, the mentally defective and the epileptic.

Ask Budget Increase

In the reorganization of the department, an increased budget has been requested providing for a deputy medical director in Sacramento, who would serve under civil service conditions as an expert adviser to the director of the department, who is a political appointee changing with each administration. At the present time there is a deputy director in charge of the administrative work, but he is not a psychiatrist, and there is no one who can be placed in charge of the psychiatric and medical problems of the department.

There are also provisions for an assistant who would be charged with the inspection of private institutions. The California law now places the responsibility for licensing and inspecting private psychiatric institutions upon the department of institutions but makes no provisions for carrying out such inspections. Such work must be done by a psychiatrist well trained in institutional procedures.

There are also provisions for setting up four mental hygiene clinics: one in Sacramento, one in Fresno, one in Los Angeles and one in San Diego. As the state has just completed the erection of the Langley

Recommendations for Improved Psychiatric Care

CONSTRUCTION

1. Sites should be obtained for new institutions in the near future.

2. The total hospital provision should be increased.

3. No increase should be made in the size of present institutions except as such an increase is incidental to the provision of a building for a special group of patients not at present properly provided for.

4. The recent policy of specializing on one story buildings should be continued, especially in view of the increase of elderly people in hospital populations.

5. A hospital should be erected for some of the most difficult patients. Its first two units should have 500 beds each, one for psychopathic and defective delinquents, the other for mentally ill persons of criminalistic history or behavior.

6. A hospital and school of 1000 beds for epileptic patients should be erected.

7. A hospital should be provided for central California. The first unit should contain 500 beds for mentally ill persons with pulmonary tuberculosis, and all such cases from the southern group of institutions should be transferred to it.

8. Necessary reconstruction and replacement should be done to abolish the fire risks that now exist. In the new buildings at Napa, ample provision should be made to care for the tuberculosis cases of northern California.

9. The Langley Porter Clinic should have more land and an addition to its building.

10. The state should proceed to acquire a site for the psychiatric clinic in Los Angeles to the development of which it is committed.

ADMINISTRATION

11. The gratitude of the state is due to institution officers and employees who stretch their hours and their efforts to cover the deficits of this difficult period. That gratitude should be both vocal and practical.

12. Highly competent psychiatric advice should be quickly available to

the director of the department. The present commendable practice of calling in the superintendent should be supplemented by having a medical inspector in the department.

13. The boards of trustees of the various state hospitals should be expected to meet oftener to study the activities and needs of the institutions and should file stated reports with the director. (They are now only advisory.)

14. The commitment laws should be revised to free patients from the burden and stigma of court appearance and transportation by peace officers.

15. The training and education of mental defectives should be still further advanced when suitable personnel is available.

16. Medical officers of these institutions and experienced employees, particularly in supervisory positions, should be encouraged to study the practice of good hospitals in other parts of the country.

17. Each institution should have at least one dietitian.

MEDICAL STAFFS

18. The ratio of physicians to patients in the California hospitals should be brought much closer to the standard recommended by the American Psychiatric Association, namely, one physician to 200 resident patients, with an additional physician for each 100 admissions.

19. Courses for assistant physicians should, and undoubtedly will, be given in the Langley Porter Clinic.

20. Every institution that lacks a clinical director should consider setting up that position.

21. The position of senior assistant physician should be created and placed sufficiently high in the scale of remuneration so that its occupants could live in reasonable comfort during a long hospital career.

22. When dentists are again available, the recommended ratio of one to each 1000 patients should be approximated.

23. Pathological work in the institutions should be maintained on a high plane.

24. Accommodations for resident physicians, as well as for the various types of employees, though not luxurious should be comfortable.

25. The offices of physicians should be on their services.

26. Medical libraries should be put in order and made adequate to the standards of knowledge that will be expected of the physicians.

27. The work of the hospitals should be reported from time to time to interested citizens and particularly through scientific communication to the several county medical societies of each hospital district.

NURSING

28. Nurse training should be introduced into several of these hospitals.

29. The services of graduate nurses should be usual rather than exceptional.

30. The position of charge nurse should be created in the civil service.

31. The ratio of ward employees to patients should be established at about 1 to 6.5.

TREATMENT

32. The present commendable effort to identify and segregate all patients with pulmonary tuberculosis should be continued.

33. The service of competent psychologists should be made available in these institutions.

34. Hospital staffs should be brought to a level where individual psychotherapy could be the rule.

35. The special therapies should be further developed after the war, especially occupational therapy, physical training, music and bibliotherapy.

36. A better standard of clothing should be established, particularly for men patients.

37. The personal hygiene of women patients should be placed on a high level.

38. Now that the planning and preparation of food are receiving more expert attention, steps should be taken to abolish all crudeness and to make its service enticing to the patients.

Porter Clinic in San Francisco, which is a 100 bed psychiatric hospital affiliated with the University of California Medical School and having an out-patient department,¹ no

¹This was described in the February 1944 issue of *The Modern Hospital*.

provision was made for a mental hygiene clinic in San Francisco.

The setup of each of these clinics is on a full-time basis and provides for two psychiatrists, one psychologist, three psychiatric social workers and two secretary-stenographers. The

Los Angeles clinic is to have twice the personnel of the other clinics and, in the plans of the department, there is provision for the building of a second clinic, in Los Angeles, similar to the Langley Porter Clinic in San Francisco. The legislature

has been asked to appropriate \$100,000 for a site for this building. The sum of \$750,000 is requested for building a 150 bed institution. When and if such an institution is built, the Los Angeles Mental Hygiene Clinic will become its out-patient department.

The budget also requests an increase in the number of psychiatrists, registered nurses, occupational therapists, physical therapists, psychiatric social workers and attendants. The department wishes to increase the amount of extramural care and feels that increasing the number of psychiatric social workers will enable more patients to be placed on parole.

The department has requested some \$63,000,000 for a postwar building program. While nothing has been finally determined, the legislature has tentatively allocated \$40,000,000 for the postwar building program and has made actual appropriations for new hospital sites and for the drawing up of architectural plans. Part of this \$40,000,000 will be expended for replacing condemned buildings in existing institutions.

It is contemplated that a new maximum security institution will be built eventually to house 2500 patients, both male and female. By agreement with the department of correction, prisoners developing mental disorders will be looked after by this department which will build a psychiatric institution for them. The maximum security institution will provide for the so-called criminally insane but not for insane criminals. It will also care for the defective and psychopathic delinquents, drug addicts and sex offenders.

A new institution for epileptics, having a 2500 bed capacity, will be built presumably in the central part of the state, about halfway between Los Angeles and San Francisco. A new 2500 bed psychiatric hospital will be constructed south of Los Angeles to care for the extreme southern part of the state. A new 2500 bed institution for the mentally defective will be constructed somewhere between San Francisco and Los Angeles.

It has been agreed that all new institutions are not to exceed 2500 beds. The existing institutions will be rebuilt according to some of the original plans and Napa and Camarillo hospitals will have 7000 beds.

One of the most important and progressive features is that every hospital will have 10 per cent of its beds set up as an acute admitting and hospital service. The plans call for installing all standard hospital equipment.

Psychiatric treatment areas will be equipped with the latest facilities for hydrotherapy, fever therapy and occupational and recreational therapy. There are also special provi-

sions for insulin and electric shock treatment so that they can be administered as indicated.

If this program can be put through,² California will have made a remarkable forward step in the treatment and prevention of mental disorders.

²The new commitment law failed to pass the legislature but most of the budgetary requests have been allowed and the name of the department has been changed to Department of Mental Hygiene.—Ed.

10 Years—2,000,000 Subscribers

ALFRED L. GOLDEN

Public Relations Director, Associated Hospital Service, New York City

“HOW did you boost your total membership to over 2,000,000? What’s happened to the New York City Plan! I am sure our readers would be interested in hearing about your educational techniques: news releases; promotional literature; house organ stories; mat service; factory posters; radio programs; public address announcements in plants; pay roll stuffers, display materials; calendar cards, wall plaques; desk novelties; paid-for-space announcements. . .”

Quite an assignment the editor has given me. Let’s take up his first item—news releases. A liberal and progressive program by our administration made these releases possible. It was primarily the increased benefits, the all-inclusive service contract, the new ward plan and the new doctors’ plan that gave us something to write news releases about.

Let’s look into his second item—promotional literature. Here, it was the liberalized enrollment procedures during the last year, the removal of restrictions and the elimination of internal red tape, that made it possible to create attractive literature.

House organ stories, mat service and posters would not mean much if it wasn’t for the enthusiasm of our field representatives.

Let’s go on to radio programs, public address systems, pay roll stuffers and display materials. All of these helped, perhaps, but more important were basic changes in our organization leading to better service to our subscribers. Take our hospital de-

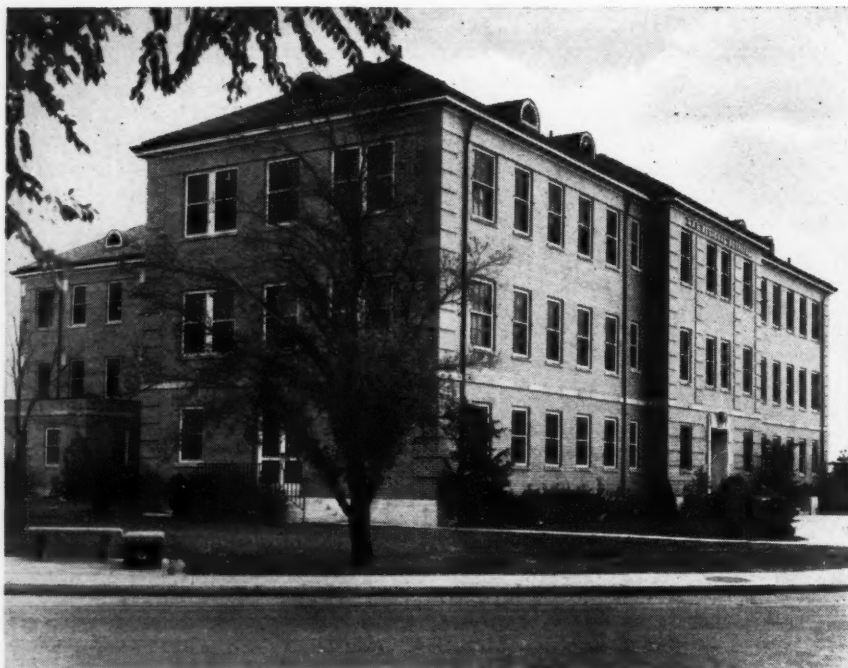
partment, for instance: during the last year a generous interpretation of that old headache known as “pre-existing conditions” created more good will for our plan than any educational technic that could have possibly been devised.

Our hospital department pays more than 600 bills in a day. Just recently there were several days during which more than 1000 bills were paid. Everything moves swiftly—our subscribers go to the hospital, their Blue Cross cards are checked at once and their hospital bills are paid without delay or red tape. Service like that is really what sells the plan.

What about the billing department? Few people realize what is involved in the prompt billing of 17,500 groups and about 300,000 individual contracts. I know of one Blue Cross plan that has a first-rate publicity program but hasn’t been able to get far because its billing is so bad. Of course, it’s beyond argument that inefficient billing leads to discontent and cancellations.

Paid-space announcements is a subject on which volumes could be written. But as a matter of fact the only paid-space announcements we had last year were those in connection with an experimental program of nongroup enrollment devised by our underwriting department.

Need I point out the significance of an intelligent and socially minded underwriting program before a plan can fully utilize every available educational medium? The answer is obvious.



POST HOSPITAL Serves Three Ways

COL. E. W. HAKALA, M.C.

Surgeon
A.A.F. Regional Station Hospital
Patterson Field, Fairfield, Ohio

THE Army Air Forces Regional Station Hospital at Patterson Field, Fairfield, Ohio, is a three story brick structure equipped to render complete service to the personnel of the field, as follows:

In-Patient Service: This consists of internal medicine, communicable disease, dermatology, venereal disease, neuropsychiatry, eye, ear, nose and throat, general surgery, obstetrics and gynecology, urology and orthopedics.

Out-Patient Service: All enlisted and officer personnel and its legal military dependents are entitled to this service through seven dispensaries, two emergency rooms and four immunization departments. Patients requiring specialized treatment are referred to specialists for consultation and care.

Convalescent Training Program: This program is divided into three categories: education, recreation and physical training. Educational training consists of ward discussions, compulsory classes on military subjects, elective classes, such as typing, woodworking, sanitation and aircraft identification, and distribution of books, papers, magazines and handi-craft equipment.

Physical training is conducted by giving calisthenics over the radio to the rhythm of music. Nurse or ward attendants supervise physical training on the wards. Athletic facilities, such as a golf course, tennis courts,

Above: Exterior of the three story Army Air Forces Regional Station Hospital in which in- and out-patient service and convalescent training are afforded to personnel. Below: The first floor includes offices, treatment rooms, clinics, food preparation and storage areas.

swimming pools, soft ball diamonds, volleyball courts, bicycles, are available for convalescent patients.

The recreation phase is coordinated between the convalescent training officer and the American Red Cross. This consists of movies, shows, parties, operas, concerts and entertainment on wards. A radio station





Above: At the post exchange convalescents purchase cigarettes, candy, magazines and numerous other items. Below: In addition to wards and private rooms, the second floor houses the kitchen and dining areas. Right: The mess hall. A special section is reserved for nurses on duty.



is located in the hospital operated by the convalescent training department. All wards have a receiver, which brings news, music and other types of programs in which the patients go down to the radio station themselves and actually participate.

A special section of the hospital is set aside for the convalescent patients who reach the conditioning point in which little or no medical care is required. These patients live in G.I.

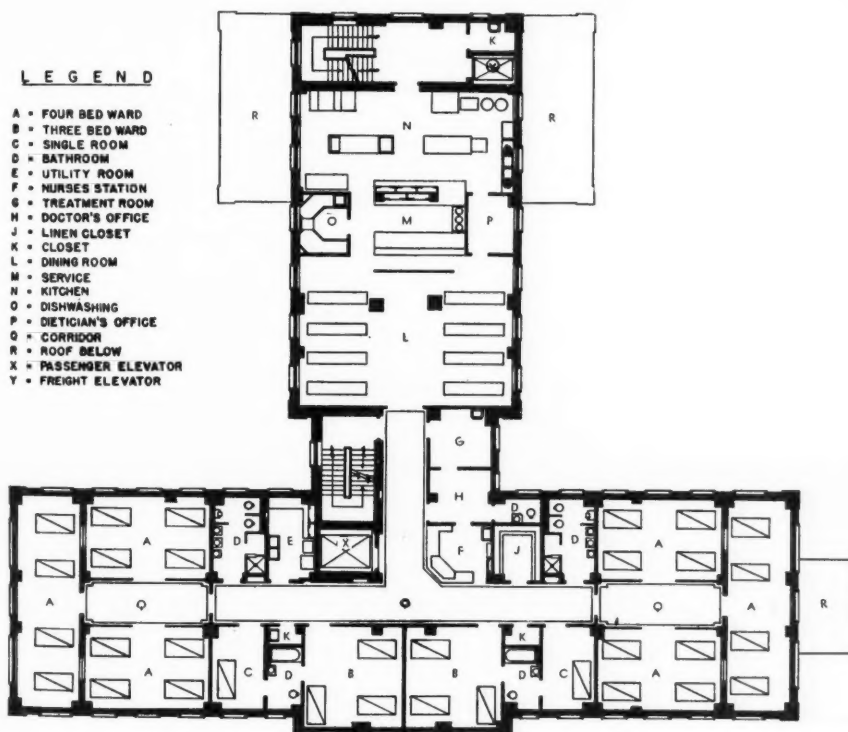
barracks, sleep in G.I. cots, stand inspection and are given pass privileges to leave the hospital.

CONSTRUCTION DETAILS

GENERAL DATA: Brick exterior with limestone trim, fireproof reinforced concrete throughout. Interior partitions and back-up of exterior walls, terra-cotta tile. Windows, double-hung wood. Interior doors, wood flush panel. Exterior, wood, glazed. Interior stairs, metal frame, metal risers, with precast nonslip terrazzo treads. Main vestibule, terrazzo floor and steps.

FLOORING: Asphalt tile with quarry tile sanitary cove base in all corridors, single and ward rooms. Toilet rooms, operating rooms, autoclave room, emergency room and preparation room for kitchen, ceramic tile floor and sanitary cove base. Kitchen and dining room, quarry tile. Stair and landings, nonslip terrazzo treads with nosings. Basement corridors, cement finish with off-rooms finished in asphalt tile.

WALLS: Dining room, kitchen, diet kitchen and stair walls, ceramic tile from floor to ceiling. Emergency room, operating room, toilet rooms and autoclave room, 8 foot ceramic tile wainscot. Corridors, single rooms and ward rooms, smooth plaster



SECOND FLOOR PLAN

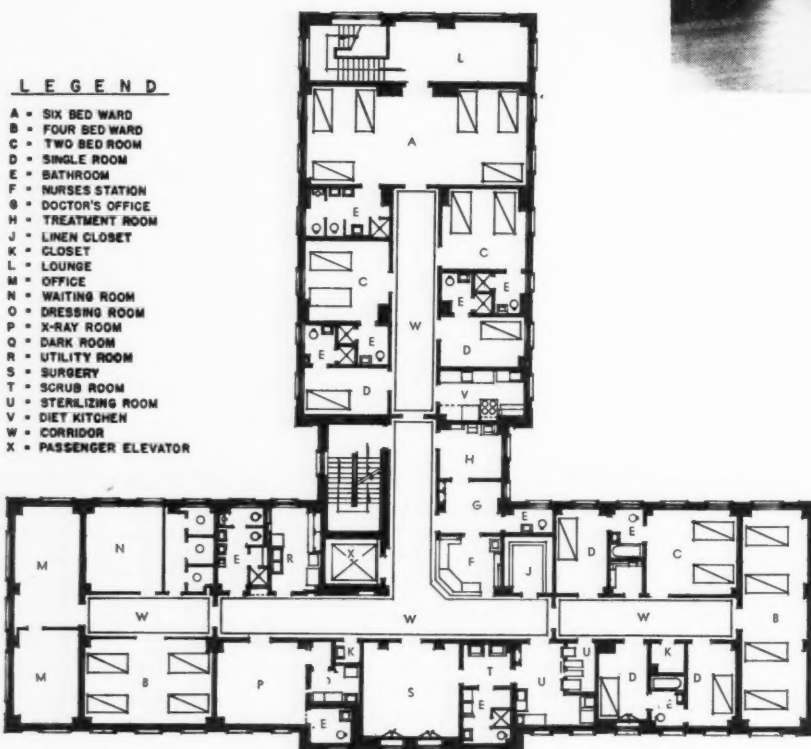


painted with three coats. Corridor in basement, glazed tile walls from floor to ceiling.

CEILINGS: Acoustic tile throughout corridors, kitchen, dining room and preparation room. All other ceilings plastered, with three coats of paint. Acoustic tile, light ivory egg-shell finish.

HEATING: High-pressure steam from central heating plant reduced to lower pressures for sterilization, cooking and hot water supply. Low- and high-pressure return lines to conserve condensate of equipment and radiation. Wall type of radiation used through-

Above: A typical ward. Right: A group of Wacs find the solarium a pleasant place to convalesce. Below: Surgery and x-ray departments are located on the third floor.



THIRD FLOOR PLAN

out with concealed radiators in parts where foot and other traffic is heaviest.

ELEVATOR: Automatic or operator-controlled. Capacity, 16 passengers or 3500 pounds; dimensions sufficient to accommodate stretcher cases.

KITCHEN: Gas ranges, broilers and deep fat fryers, electric ovens, aluminum steam kettles, vegetable steamers, vegetable chopper and mixer, steam-heated coffee urns. Steam tables and central service units, stainless steel.

CABINETS: Welded steel with coved construction; counters and shelving, stainless steel; door stiles and rails, stainless steel.

VENTILATION: Exhaust from all toilets and baths, wards, kitchens and elevator shafts. These systems are all separate.

CALL SYSTEM: Push-button type at beds with lights over doors and pilot lights at nurses' stations. Wards equipped with bull's-eye indicators at beds. Two-way communi-

cation systems between various offices and rooms. Public address system wired to each bed for headphones with choice of programs. Control cabinet equipped with microphone to cut in for announcements and emergencies.

LIGHTING: Semi-indirect and fluorescent used throughout with night lights in patients' rooms.

EMERGENCY LIGHT AND POWER: Gasoline-powered generator located in transformer room to furnish emergency light and power.

AIR CONDITIONING AND REFRIGERATION: Surgery and two recovery rooms, air conditioned with complete change systems and do not use the same air. Eye, ear, nose and throat rooms, air conditioned with partial air changed. Offices and x-ray rooms, air conditioned with recirculatory systems. Ice water piped throughout building and handled with three units. Walk-in coolers for meats, vegetables and dairy products. Ice cube makers, capacity 1000 pounds, twenty-four hours. All air conditioning and refrigeration, Freon 12. Capacity, 15 tons.

We Can't Wipe Out Tuberculosis

unless we go and look for it

KARL H. PFUETZE, M.D., and ROBERT P. GLOVER, M.D.

Respectively, Medical Director and Superintendent, Mineral Springs Sanatorium
Cannon Falls, Minn., and Fellow in Surgery, Mayo Clinic, Rochester, Minn.

PUBLIC health authorities have long been agreed that the prevention of a communicable disease, or its early discovery and treatment, is essential for its ultimate elimination. Immunization methods so successfully accomplished in smallpox, diphtheria and typhoid have not materialized to date against tuberculosis. Thus, the fight against tuberculosis must necessarily resolve itself into a relentless campaign of case-finding. What existing efforts in this direction have already been made and what has been their measure of success?

In the first place, early diagnosis campaigns urging individuals with certain symptoms to submit to an examination have proved inadequate. An amazing number of people with extensive and occasionally spectacular disease do not have enough symptoms to arouse the suspicions of the patient, his family or physician.

Second, case-finding surveys in tuberculosis have largely been confined to examining contacts of known cases and to skin testing programs in schools and colleges. Such programs, while important and indispensable, have been inadequate and too limited in scope for, despite these measures, from 50 to 60 per cent of patients in our sanatoriums *still* have far advanced disease on admission.

Eliminate Danger of Spread

It is well known that tuberculosis can usually be arrested when discovered early and treated adequately. However, since early tuberculosis causes no symptoms it must be searched for among people who have no symptoms referable to the chest. By discovering tuberculosis in an early stage, not only can the disease in this individual be arrested, but the danger of spread to other persons is eliminated.

Minnesota has long been one of the leaders in the fight against tuber-

culosis. The best of medical care is available in this state to everyone with known tuberculosis. Ours is one of the few states which have an adequate ratio of sanatorium beds to tuberculosis deaths. About \$2,000,000 per year is spent in the care and treatment of our tuberculous patients.

All this is fine and as it should be. But it is not enough! We now have the facilities available and the necessary knowledge to reduce tuberculosis to the status of a minor disease if we will only use them to the fullest extent. Our major problem at present is the lack of an adequate case-finding program. Mass surveys of industrial workers, students and Army inductees have clearly demonstrated their effectiveness in discovering unsuspected tuberculosis. However, one large reservoir of tuberculous infection has thus far been largely overlooked, namely, patients admitted to our general hospitals.

Routine radiologic chest examination of all patients admitted to hospitals or clinics has often been proposed, but in only a relatively few institutions has it been carried out. Some 17 years ago Ralph Kinsella in St. Louis started such a program in St. Mary's Hospital, a voluntary institution. This procedure was carried on for several years, using 14 by 17 inch films, but was abandoned during the depression for financial reasons. During this period Kinsella found that the incidence of tuberculosis discovered on admission rose about 100 per cent. Clinicians are generally agreed that no examination is complete without a chest x-ray. But because of the expense involved, few institutions have been able to take regular size films on all admissions.

At Grasslands Hospital, Valhalla, N. Y., during an eighteen month survey period, 7187 of 9693 patients

admitted to the hospital or its outpatient department were examined with 14 by 17 inch chest films. Of this number, 2.8 per cent showed evidence of reinfection tuberculosis. Active or questionably active lesions were found in 0.6 per cent. As is well known, the Mayo Clinic has for many years routinely made x-ray examinations of the chests of all admissions.

Beginning in the 30's, in order to reduce the expense, a number of hospitals and clinics began to do fluoroscopic chest examinations on all admissions. Whenever the fluoroscope revealed abnormal findings a regular size film was taken.

Findings Justified Expense

The University Hospital in Minneapolis inaugurated such a program in 1939. During the first ten months, of 4391 cases examined, 1766 had positive findings of one kind or another, including 26 cases of active tuberculosis, eight cases of lung tumor, eight mediastinal tumors and 733 enlarged hearts. Significantly, less than 20 per cent of these patients had any symptoms referable to the chest. The medical staff concluded that the number of unsuspected open cases of tuberculosis found would alone have justified the time and expense involved.

At the University of Chicago Clinics routine fluoroscopy of the chest of all patients has been an accepted procedure for a number of years. Of the first 15,000 patients thus examined, 1.43 per cent were found to have clinically significant tuberculosis. In addition, a large number of other chest conditions were discovered, the most important of which were malignant neoplasms (1.6 per cent) and cardio-vascular disease (14.4 per cent).

Tucker and Bryant examined by

Presented at the Minnesota Hospital Association meeting, May 1945.

fluoroscopy and x-ray 1000 consecutive patients attending the prenatal clinic of Provident Hospital in Chicago. They found that 1.8 per cent of the cases had unsuspected clinically important tuberculosis. This incidence was found to be approximately the same as for other non-pregnant women of the same age groups examined at this hospital.

Eisle and his associates at Chicago Lying-In Hospital reported an incidence of 1 per cent unsuspected clinically important tuberculosis discovered among patients there by the same procedure, and 0.7 per cent were shown to be active during pregnancy.

Just what is the significance of discovering this 1 per cent? It is interesting to note that among 82,000 obstetrical patients in eight other Chicago hospitals that did not use tuberculosis case-finding methods, only 55 cases, or 0.067 per cent, were found to have tuberculosis—or about one fifteenth as many. It is even more striking to note that the incidence of active tuberculosis found in that survey was ten times greater than that found in similar groups where no case-finding methods were used.

Error Can Be Eliminated

Where else in medicine is a 90 per cent diagnostic error tolerated when simple adequate methods are available for elimination of that error? Nor are private obstetrical patients spared the ravages of this disease. Graham found by routine chest x-rays of 800 consecutive private obstetrical patients that 1 per cent had active tuberculosis.

Let us not be lulled into a false sense of security engendered by the decline of tuberculosis mortality rates. Tuberculosis *still* kills more women in the child-bearing age than does any other disease.

In 1941 the University of Michigan Hospital began to take miniature (35 mm.) chest films on all patients admitted. During the first four months of operating the miniature x-ray unit, 9.3 per cent of those examined were found to require further roentgenologic study. Dr. F. J. Hodges, head of the radiology department, believes that such surveys of entire hospital populations are most effective in finding unsuspected open cases of tuberculosis capable of transmitting the disease to other patients and hospital personnel.

Tuberculosis among the veterans of World War I has already cost the United States government well over \$1,000,000,000. With the advent of World War II the Army decided to attempt to eliminate all significant tuberculosis among the recruits by routine miniature x-ray examination of each person on induction. When the small film (4 by 5 inches) revealed abnormal findings, large films were taken. In Minnesota this procedure has resulted in the rejection of more than 0.6 per cent of the inductees because of active or potentially active tuberculosis—this, mind you, among *apparently* healthy men between 18 and 35.

Early in this war the United States Public Health Service began mass miniature x-ray surveys among workers in war plants and other industries. Of the first 1,000,000 workers thus examined, 1.5 per cent were found to have reinfection tuberculosis. Sixty-five per cent of these cases were in the minimal stage; 30 per cent were moderately advanced, and 5 per cent were far advanced. This is almost a complete reversal of previous experience when not more than 10 per cent of the patients admitted to sanatoriums were in the minimal stage of the disease.

Minnesota has gained national prominence from the tuberculosis survey now being conducted in St. Louis County. An attempt is being made to take a miniature chest x-ray of every person in the county who will stand still long enough to have it taken. At Ely, Minn., for example, more than 98 per cent of the total population was examined with miniature x-ray films. The mobile unit there, operated by the Nopeming staff, has been in operation since October 1943. Of nearly 35,000 persons examined during the first year, 1.7 per cent were found to have significant tuberculosis. Of this number, 66 per cent were in the minimal stage.

From these figures, the value of routine radiographic examination of patients admitted to clinics and general hospitals is evident. In every institution in which such procedures have been inaugurated, the physicians feel that the results have more than justified their continuance. It is hoped that soon all general hospitals will provide routine x-ray examinations of the chest just as they are now asking routine serologic

tests for syphilis. In this respect, surveys have shown that routine radiologic chest examinations will reveal more positive findings than do the tests for syphilis.

Small film radiography is well suited to case-finding in general hospitals. In 1943, more than 15,000,000 persons were admitted to general hospitals in the United States. Routine chest films taken annually on this number, in addition to industrial and other mass surveys contemplated, would in a few short years uncover the vast majority of tuberculosis cases now endemic in our population. Tuberculosis in cattle has been practically eradicated in the United States in the last twenty-five years. Why should we give our calves greater protection than we give our children?

Cost Is Not Prohibitive

The old objection to routine radiographic examination of patients because of the prohibitive cost is no longer valid. Using the miniature film as a screening method, the cost to the individual patient is negligible. The total cost per small film in the St. Louis County Survey, during the first year of operation, was \$0.53. Obviously, in a hospital, using stationary equipment, the cost would be considerably less. A nominal charge added to the patient's laboratory service fees would make little difference in the total hospital bill. The hospital could easily show a small profit from such a program and at the same time amortize the original investment. There would naturally be a definite increase in the number of 14 by 17 inch films that would have to be taken to follow up any abnormalities uncovered by the small films.

The cost of the small film equipment varies considerably, depending on the type and size desired. An investment ranging from \$1800 to \$10,000 would equip any hospital with a small film unit adequate for its needs.

Under the direction of Dr. L. G. Rigler of its radiological department, the University of Minnesota Hospital is planning to install a 70 mm. film unit within the next few months. This equipment will be used for the routine chest examinations of patients admitted to the University Hospital and the outpatient clinic, employees, nurses and

professional staff and all of the University of Minnesota students.

I understand that Ancker Hospital in St. Paul, Minneapolis General Hospital and at least two large volunteer hospitals in Minnesota are planning to install similar units when they are available.

Hospital administrators are familiar with the problem of tuberculosis developing among student nurses and other hospital personnel. The incidence of these casualties varies

in different institutions and in different parts of the country but the hospitals cannot and must not evade their responsibility to protect their nurses from all unsuspected open cases of tuberculosis. Routine x-ray examination of patients, nurses and employes not only will disclose unsuspected tuberculosis, which is extremely important to the individual, but will protect other patients and employes from the danger of infection with the disease.

The medical faculty of Albany Medical College will continue as it has in the last ten years to teach the sciences in the school of nursing. The nurse members of the faculty, each of whom has specialized in her particular field, are responsible for the nursing arts program and for the teaching and supervision of the students during their assignment to the clinical services. All faculty appointments are made by the board of trustees.

A modern fire-resistant residence on the hospital grounds accommodates 100 students and 40 other personnel. A postwar expansion program includes a large addition to this building. At present, however, to take care of additional students, two apartment houses in the immediate neighborhood have been converted into living quarters for 200 students. Each of the three buildings is in charge of a residence director.

The school, which anticipates a maximum enrollment of 300 students, will admit its first class early in September. For the time being, superior high school graduates as well as applicants with two or more years of college may be accepted. A diploma in nursing will be given on the completion of the three year program. In addition, a bachelor of science degree will be conferred by Union University on those students completing the course whose pre-professional preparation includes two or more years of college work that is acceptable to the university and to the New York State Department of Education.

The program covers three years, the first six months of which are devoted to preclinical study. In the last two and a half years students will, in addition to their professional study, have clinical experience on the wards of the Albany Hospital. Students will have practice nursing in all services, including communicable disease, tuberculosis and psychiatric nursing, as well as the usual experience in medical, surgical, obstetric and operating room nursing.

The New York State Board of Nurse Examiners has approved of the admission of students to this new program and application has been made for student participation in the U. S. Cadet Nurse Corps. The school is registered with the University of the State of New York.

A New School in an Old Setting

ESTABLISHED in 1897 to meet the nursing needs of Albany Hospital, Albany, N. Y., the hospital training school for nurses over the intervening years has been strengthened and broadened through the constant efforts of its nursing leaders to raise its educational and professional standards. The founding in 1944 of Union University School of Nursing as a division of Albany Medical College is the culmination of ten years of activity directed toward bringing nurse education at Albany Hospital to the college level. The school is affiliated with a group of institutions whose background is rich in pioneering traditions. Albany Medical College, one of the oldest institutions of its kind in New York State, was established in 1839. When, in 1873, Union University was organized, Albany Medical College was one of the four institutions that united to form this university. Albany Hospital, founded in 1851, has since its inception provided clinical experience for the teaching and practice of medicine and for more than half of its existence has supplied clinical experience for students in schools of nursing.

In 1934 the governors of Albany Hospital decided that the development of a collegiate program of education for nurses was a sound policy and that it would be desirable for Albany Hospital to participate in such a program. An affiliation was developed in 1935 with Russell Sage College in Troy, N. Y., whereby the

students could obtain their education in liberal arts at the college and their professional preparation at Albany Hospital.

The program for the school covered a period of four years and students, on its completion, were eligible for a diploma in nursing and a bachelor of science degree. Because of certain deficiencies in this program, it was decided to discontinue it and change to a five year program in which the students remained at Russell Sage College for the first two academic years and were in residence at Albany Hospital for the remaining three years.

After deliberation and conferences with Russell Sage authorities, the decision was made by Russell Sage College that it will hereafter accept applicants for a two year or a four year prenursing course and the students will be given a choice of institutions offering college programs at which the nursing education may be completed; the school at Albany Hospital will be one of these. Coincidentally, Albany Hospital decided that a three year course on a collegiate level, accepting students with two or more years of college, was desirable and it was decided to organize a nursing school as a part of the group of institutions that combine to make up Union University.

ELIZABETH A. BELL

Director
Union University School of Nursing
Albany, N. Y.

*Psychiatric affiliates
set their seal on*

Library Service

KATHRYN BEADLE, R.N.

Clinical Supervisor in Psychiatric Nursing
Illinois State School of Psychiatric Nursing, Chicago

THE new group of students had just arrived and was looking over the posted course of study and its list of correlated ward experiences.

"Look! It says a week in the library!" "In the library? I don't know anything about library service, do you?" "You must be wrong, we don't have anything to do with the library, except to read a few references there, I guess." But time and experience soon corrected this error.

The librarian and the instructor had cooperated in the plan to give to each cadet and affiliate at least a week in the library's busy, quiet and colorful atmosphere. This program included the following activities:

1. An hour each day of instruction by the librarian on the function of institutional libraries.
2. Instruction in the method of cataloging and arranging books.
3. Practice in shelving books.
4. Helping ambulatory patients to choose suitable books.
5. Compiling a notebook of suggestions of appropriate reading for various types of patients (this was best done slowly from the considered comments of patients as books were returned).
6. Reading such articles as the following for discussion with the librarian: "Bibliotherapy—The Use of Books as a Form of Treatment in a Neuropsychiatric Hospital," by G. O.

The author was formerly a graduate student in advanced psychiatric nursing at Rochester State Hospital, Rochester, Minn., and a graduate of Kahler School of Nursing, Rochester.



Ireland, M.D.; "A Library for the Feeble-Minded," by Tordis M. Heyerdahl; "Library Hospital Service in Sioux City," by Rose A. O'Connor; "Balanced Reading Diet Prescribed for Mental Patients," by Dr. Gordon R. Kamman; "The Selection of Modern Fiction for Hospital Use," by Esther F. Morris; "Prescribing Books for the Sick," by Louise Sweet, and "Stepping Up Circulation in Mental Hospital Libraries," by Magnus C. Petersen, M.D.

7. Visiting wards daily for the distribution of books to patients unable to come to the library to choose reading material.

In this brief period by the close correlation of theory and practice in bibliotherapy each student nurse learned much of the stimulating value of an active library service for mental disease patients.

"You should have seen how happy he was when I found a book on his 'pet' subject." And again, "She never fails to read that periodical the first day it is put out on the rack." "Those two wouldn't miss reading

the home-town weekly from beginning to end, would they?"

It was noted, also, that the nurse was less likely to greet her comrades with the banal "What do you know?" and more likely to ask, "What have you read lately?"

There was a growing appreciation of the possibilities of the library as a social center. Perhaps its wide sunny windows looking out on the peaceful fields suggested gatherings for tea or for discussions of book reviews or current events. "It would be nice to have a planned listening hour for special radio programs." "Talking over the bulletin board displays is always interesting in the library."

Student comment set its seal on the value of library service. "I've always wanted to know how a library worked." "I'd like another week here later, so I can see what the patients are reading then." "There is plenty to learn about the approach to patients while you are giving out books on the ward service."

The library thus continued to contribute to the happiness and welfare of all, patients and employees alike.

Giving Has Gone Democratic

Now the fund raiser and administrator must be prepared to interpret their services to their new partners in health

A. A. HECKMAN

General Secretary, Family Service
St. Paul, Minn.

VOLUNTARY giving for organized health and welfare services has reached an all-time high. Few properly organized financial campaigns for any kind of community services have failed. The Community Chests and War Chests, for example, have broken all existing records in their campaigns for the last two years.

In St. Paul prior to the war, we had to work hard to raise \$725,000 for our local Community Chest. It took as much effort to raise smaller sums for agencies that were not affiliated with the Community Chest, for churches and other welfare and health agencies. When it was decided to try to raise \$1,300,000 for the War Chest, many people were skeptical. The campaign exceeded its goal by a sizable amount. Then, within a few months, came the Red Cross campaign seeking to raise nearly \$750,000. Experienced money raisers doubted that this could be done in such short time following the War Chest campaign. The Red Cross, too, exceeded its goal by a sizable amount.

Will It Be Easier Now?

Do these results of 1942-43-44 mean a new era in voluntary fund raising? Is it going to be easier to raise money from here on? Are there factors related to these financial successes that may have direct and important relationships to the administration of health and welfare services? Let's look at the recent Community and War Chest campaigns inasmuch as they represent one of the largest efforts in voluntary money raising and

we have reasonably complete data for them.

One thing of significance is the increasing number of contributors.* For 196 chests, on which data are available, we find that in 1943 they received contributions from one out of every four persons in the population served. Of 25 average contributors, 16 contributed less than \$5 each and only one made a gift of \$25 or more.

For 110 chests used in a trend study, the number of contributors increased 25 per cent from 1942 to 1943 and 81 per cent over the average during 1935 to 1939. The number of contributors of \$100 or more increased 41.8 per cent over the base period of 1935 to 1939. The number of \$5 to \$9 contributors increased 133.8 per cent and those between \$10 and \$24 increased 160.5 per cent. The largest increase was in gifts of \$25, 000 and over, where the percentage increase was 213.3 per cent over the base of 1935 to 1939.

At least two important factors enter into these successes: first, increases in big corporation gifts both in numbers and in amounts and, second, increases in the total number of contributors—especially in the smaller gifts bracket.

War prosperity and the form of the present corporation tax structure make possible large contributions from corporations. War prosperity, plus active and organized support from organized labor, has been responsible for a large part of the great increases in the numbers of smaller contributors.

It is generally recognized that in the case of large individual and cor-

porate gifts, the present tax structure diverts money from the federal treasury to private health and welfare activities, for frequently 90 per cent or more of the gift otherwise would be paid in taxes. This situation seems unlikely to continue in the postwar period.

A decrease in the hours of employment will materially reduce the "take home" pay of many wage earners. The patriotic appeal of war-time needs, which has increased collections for all privately supported health and welfare services, also will be lacking when the war ends.

There is no reason to expect that incomes from endowment, which shrank as interest rates dropped in the years following the 1929 crash, will do better than stabilize near the present level. Inheritance taxes and income taxes long ago affected the building up of endowments through gifts and bequests from wealthy individuals. Fees and collections for part-pay services generally are up, another favorable factor in financing voluntary services. These, too, can and probably will drop.

Current Trends Will Change

Therefore, in terms of dollars there is little reason to expect a continuation of the current trends in giving and the present favorable experiences in money raising. Tax readjustments now in view seem likely to reduce the present generous rate of corporation contributions.

We probably will come to depend increasingly upon contributions from the lower income groups and real progress has been made in building up contributions from this source. Organized labor has demonstrated its ability to produce results. Such

Presented to the Continuation Course in Hospital Administration, conducted by the Center for Continuation Study for the American College of Hospital Administrators, January 1945.

*All statistical data are from Bulletin No. 118, August 1943, Trends in Community Giving, Community Chests and Councils, Inc., New York City.

campaigns as I have been discussing for the most part have had its wholehearted endorsement. Industrial solicitation has brought not only an increase in the number of gifts but also marked increases in the size of such gifts.

However, there are aspects of these trends that go beyond the mere financial implications. They should concern all of us who are administrators of agencies dependent upon voluntary gifts for all or a part of their support.

Labor Will Take Part

In the first place the "honeymoon" with labor is over. We have been patting each other on the back for our joint results in money raising. Now we must settle down to living and working together. Labor is not now and will not be content just to contribute to the health and welfare activities; it knows that its members for the most part are the chief immediate beneficiaries of such services. If labor supports such activities it also wants to share in their administration. Some of us already are experiencing this new interest and desire. The day is rapidly disappearing when boards of directors were composed of a few wealthy and influential men and women who asked few questions and let the administrator run the program pretty much as he pleased.

These newcomers to boards of management have had more firsthand experience with the receiving end of our program than they have with the management. They have ideas about what ought to be done based upon their own and their friends' experiences. They ask questions. They suggest, in fact urge, changes. They have an uncanny faculty of cutting through the froth and trimming and getting to the very heart of an issue.

To date, we have not done a particularly good job of interpreting our services to the rank and file. Therefore, they are bewildered about our true aims and purposes and about some of our limitations, as well as our strengths. We will have to do a better job from now on in interpreting what we are doing and why we are doing it the way we are. We also will need to help interpret labor to the old board members who have been unaccustomed to working with rank and file representation.

There is another phase of this new participation in financing and managing our services. These same people, to a large extent, will be participating through income taxes in financing governmental services. In the postwar period they will have to provide a sizable share of the additional revenues needed for governmental services. If the treasury took all of the total net taxable income of all persons with incomes of \$5000 a year or more, it would raise only \$15,000,000,000 of the \$18,000,000,000 to \$20,000,000,000 budget needed in postwar years.

These are the people who elect congressmen and senators, who place parties in power and who vote them out. I think the 1944 national elections provided pretty conclusive evidence of this fact. The administrator's plans for services will have to be accepted as sound by a public faced with higher tax payments and reduced incomes.

One result is quite likely to be the forcing of economy upon governmental officials at every level at the same time that increases in certain services are requested. Demands will be made for better and more efficient services, more intelligent planning and more effective spending of the taxpayers' money.

Privately financed health and welfare agencies will be directly affected by the same tax problems that beset public agencies. Trends and developments in public welfare also will be reflected to a great degree in voluntary agencies.

As members of this new group become familiar with the details of their local health and welfare program, they will become increasingly aware of relationships—of the effects of one type of problem upon another kind of problem and of one service upon another. They will not be steeped in, or impressed by, the traditions of our particular individual agency's program.

Not only will more careful planning and policy-making be required within the health and welfare field itself, but these services must be related to other public services—local, state and national. I am convinced that organized labor will demand greater participation in planning. It certainly has in the industrial field and the recent activities of P.A.C. indicated its intentions and strengths in the political field.

For example, I believe the year is not far away when leaders in organized labor will recognize quite clearly that hospitals are more than institutions with beds and doctors. They will see them as an important part of a total program of a community aiming (1) to eliminate the dangers of physical and mental illness and handicaps; (2) to ensure adequate diagnosis and treatment and rehabilitation when handicaps do occur, and (3) to ensure the maximum productivity and happiness of its citizens through the protection of the health of the individual. They will see more clearly than before that ever-changing social, industrial and cultural conditions are bound to bring marked changes in health objectives, as well as in therapeutic and preventive programs. They will want the kinds of programs and relationships between agencies that recognize this.

In my particular field it is already evident that some of the leaders in organized labor know more about the total community picture than do some of the individual agency executives who have been so steeped in their own problems and in their own little show that they either haven't had the time or haven't taken the time to see what the relationships are between their agency's program and the total community welfare program.

Will Demand Better Service

Increased income and such projects as the Blue Cross plans, the E.M.I.C. program, cash grants for health and welfare services and allotments, to say nothing of the experiences the men and women in the armed forces have had with both health and welfare services, will greatly affect the kinds and quality of services we render in the future. I think the public is going to demand better services than we have ever given before, and in many cases this is going to cost more money at just the time when money will be the least plentiful.

For example, social security with its cash payments, its allowances for medical care and more adequate budgets has prevented relief agencies from going back to the practices of meager grants in kind so prevalent in the 20's and early 30's.

Likewise, I question whether people who have become accustomed to

care in voluntary hospitals will return to governmental hospitals and be satisfied with some of the conditions and practices of the 30's, such as the long waiting periods in outpatient clinics and being used for teaching and demonstration purposes.

We also can look for some new developments to which we will have to make adjustments. For example, the C.I.O. already has started to train men in every shop to be counselors. By "counselors" it means someone acquainted with the resources of the community and the intake procedures and policies of the

social agencies. The members of the union may turn to them for advice in obtaining services needed.

In some cities organized labor groups have set up such services as clinics under their own auspices but supported with contributions from the Community Chest. Others have started having trained social workers paid from union funds to serve their own membership. These developments affect relationships, program content and financing.

The likelihood of losing considerable money from corporation gifts may be offset in part if we are successful in interpreting to corpora-

tions their responsibility for health and welfare programs in the local community.

I take social progress for granted even in the face of difficult problems of finance. Postwar progress will include an expanded and strengthened social security program. Certain phases of public and voluntary health and welfare work must be broadened. But continued accomplishments will be achieved by means of sound research, more intelligent planning and greater cooperation between public and private agencies rather than through any marked increase in funds available.

VOLUNTEER ACTIVITIES

Volunteers From Britain

Volunteer service took a new turn at St. Luke's Hospital, New York City, when Leading Aircraftsmen W. Victor Burn and Leslie W. Fryer of the British Royal Air Force Medical Service reported for duty. Their ship plies regularly between London and New York but on this occasion the vessel needed overhauling. Hearing that male personnel was at a premium in the hospitals, they came to St. Luke's offering to help in any way they could. They fitted into the staff like veterans, the hospital reports.

They Handle Oxygen Apparatus

A small group from the Men's Volunteer Corps at Wesley Memorial Hospital, Chicago, assists the evening oxygen technician. As a part of their training these men spent one or two days at one of the oxygen equipment companies in the city so that they could proceed to handle the delicate apparatus intelligently. Wesley's other men volunteers are trained on the job. Along with women volunteers they must attend an orientation lecture given by the director of volunteer services during the first month of service.

Gives Second X-Ray Machine

Back in 1933 when the auxiliary board of Alexandria Hospital, Alexandria, Va., presented an x-ray machine to the hospital, it established a perpetual memorial to the board's deceased members in the form of an x-ray trust fund. The interest on this fund was to replace the machine when it became necessary. New x-ray equipment was recently installed and, in addition to the income from the trust

fund, the auxiliary donated \$3000 toward its purchase.

Hear Special Lecture Series

Women's auxiliary members at Montefiore Hospital, New York City, are pleased over the decision to extend them the privilege of attending the lecture series given to the board of trustees. Heads of the various medical services and of administrative departments give the lectures.

Don't Overlook Rural Women

Among the four branches of the Women's Hospital Aids of Public General Hospital, Chatham, Ont., is the North Harwich Assisting Society, an organization of rural women who have accomplished programs of almost incredible proportions in maintaining community hospital service.

Vie for Top Position

Volunteers in the New York City area are spurred on to greater effort by the publication of their work records in the *United Hospital Volunteer Review*. Each month those who worked 100 hours or more and those who have top records in 31 hospitals are listed. Some of the volunteers put in more than 200 hours a month. There is great competition for the first position on the list.

Auxiliary Aids a Come-Back

To further the war effort, Allen Memorial Lutheran Hospital at Waterloo, Iowa, reopened its nursing school in 1942 and the first class is being graduated next fall. The students go by bus to Iowa State Teachers College

a few miles distant for their preclinical studies and they broaden their training through an affiliation with Cook County Hospital, Chicago. The women's auxiliary gives a scholarship to one student in each class.

The auxiliary's other contributions take the form of canning fruits and vegetables at the hospital, mending hospital linens and making infants' gowns, surgical towels, curtains and draperies. The Lutherans took over this hospital in December 1938 after it had been in a receivership and its service had deteriorated sadly. The auxiliary has been a factor in assisting Supt. Rubie M. Carlson and the board in bringing the institution back into public favor.

Sale for Scholarships

Evening dresses, sports clothes, millinery, shoes and costume jewelry poured into Patten Memorial Hall at Evanston Hospital, Evanston, Ill., in mid-April for the annual Resale held by the women's auxiliary. The nursing committee called for all donations that could not be delivered to the hall.

The women pushed this year's Resale hard for their purpose had been stated by Surgeon General Thomas Parran in these words: "It is my judgment that nurses who are engaged in necessary teaching of cadet nurses contribute more effectively to our nation's total war effort than they could in military service."

The sum of \$700 was raised and all of it will go to provide scholarships for selected members of each graduating class to take advanced work in nursing education.

Administrators

S. A. Ruskjer, administrator of Mason Memorial Hospital, Murray, Ky., and of Paducah City Hospital, Paducah, Ky., has been selected as superintendent of Waverly Hills Tuberculosis Sanatorium at Waverly Hills, Ky. Mr. Ruskjer has been in the hospital administration field for thirty years. He is the founder and president of the West Kentucky Hospital Council and is now president of the Kentucky State Hospital Association.

Harold B. Burr, assistant administrator and formerly business manager of the City Hospital, Akron, Ohio, has accepted the position as administrator of Lima Memorial Hospital, Lima, Ohio. Mr. Burr is a member of the A.C.H.A. and A.H.A. and of the Ohio Hospital Association.



J. L. Procope, superintendent of Flint-Goodridge Hospital of Dillard University in New Orleans, has been named superintendent of Provident Hospital in Baltimore. He will assume his new duties September 1.

Lt. Col. Jack Segal, M.C., has been named executive officer of Gardiner General Hospital, Chicago, replacing **Lt. Col. Rufus Moore Jr., M.C.**, who has been transferred to Army and Navy General Hospital, Hot Springs, Ark. Colonel Segal returned recently from Germany where he commanded the 47th Field Hospital which landed in Normandy last summer and followed the First Army through all of its campaigns.

Mrs. Corinne L. Starford, R.N., has resigned her position as superintendent of Grafton City Hospital, Grafton, W. Va., where she has been superintendent since 1936.

Murray Fertel has been appointed executive director of Jewish Memorial Hospital in Boston. He was formerly assistant superintendent of Beth Abraham Home for Incurables in New York City. **Albert I. Lipton**, former camouflage engineer for the Army, has been appointed to succeed Mr. Fertel.

Eva M. Dickson, R.N., has been named superintendent of Greenville Hospital, Greenville, Pa.

Sister Alice Epp of Mennonite Deaconess Hospital, Beatrice, Neb., has been appointed superintendent of the hospital,



succeeding **Mrs. Ursula Penner Frantz**, who has resigned. **Richard C. Wieve** of Beatrice has been named business manager, a newly created post.

F. Stanley Howe, director, Orange Memorial Hospital, Orange, N. J., is acting as consultant in the preparation of plans for a 400 bed teaching hospital for the American University of Beirut, Syria. The architect is **W. Stewart Thompson**, New York City.

J. Milo Anderson, assistant superintendent of the University of Chicago Clinics and superintendent of Chicago Lying-In Hospital and Dispensary, will go to Methodist Hospital at Gary, Ind., August 15 as administrator. Mr. Anderson completed the course in hospital administration at the University of Chicago this year. He will succeed **Rev. James Lawson** at the Gary hospital.



Dr. Emil G. Chinlund, director of Immanuel Hospital and Deaconess Institute at Omaha, Neb., for more than twenty-five years, has resigned, but will remain in office for the remainder of the current year.

Marguerite M. Ducker, research assistant in the program in hospital administration at Northwestern University, has been awarded the S. S. Goldwater Fellowship in Hospital Administration at Mount Sinai Hospital in New York City. A year's leave of absence beginning September 1 has been granted to Miss Ducker to take advantage of the fellowship, after completion of



which it is expected that she will return to the teaching staff in hospital administration at Northwestern.

Agnes Bergh, R. N., superintendent of Warren Hospital, Warren, Minn., has resigned.

Brother Silverius, C.F.A., has been appointed administrator of Alexian Brothers Hospital in Chicago. Brother Silverius has been active in all organizations of his profession and is chairman of the men nurses' section of the Illinois State Nurses' Association and secretary of the men nurses' section of the American Nurses' Association.

John F. Barker, deputy superintendent of Gallinger Municipal Hospital, Washington, D. C., has accepted the position of executive director of Vicksburg Clinic and Hospital, Vicksburg, Miss. He will assume his new duties on August 15.

Department Heads

Lt. Col. Steige D. Blackford, M.C., of Charlottesville, Va., is now chief of the medical service at Valley Forge General Hospital, Phoenixville, Pa. He succeeds **Lt. Col. Maurice A. Schitker, M.C.**, who has left for an overseas assignment. Colonel Blackford recently returned to this country after thirty months of service as chief of the medical service of 8th Evacuation Hospital in North Africa and Italy. He was awarded the Legion of Merit for his work with the hospital.

Eleanor Brentwood O'Hara has been appointed director of medical social service for the Home for Incurables, New York City. Miss O'Hara was formerly affiliated with Albany Hospital at Albany, N. Y., and, more recently, was employment director of Williams Press, Albany.

Frances Barbour has been appointed personnel counselor to student nurses at Missouri Baptist Hospital in St. Louis. For the last year Miss Barbour has been with the Department of Justice in Washington, D. C., in personnel work.

Mrs. Sally R. Brown has been appointed director of the housekeeping department at Nassau Hospital, Mineola, N. Y. Mrs. Brown succeeds **Mrs. Mabel W. Rozett** who resigned because of ill health. Mrs. Brown was formerly head of the housekeeping department at South Nassau Communities Hospital, Rockville Center, N. Y.

Grover Boone has succeeded the late **William W. Davison** as chief engineer at Passavant Memorial Hospital in Chicago.

(Continued on Page 150)

SMALL HOSPITAL FORUM

Plan Today for Tomorrow's Purchases

PEARL R. FISHER, R.N.

Superintendent, Thayer Hospital
Waterville, Me.

HOSPITAL administrators and boards of trustees might well review and audit their purchasing policies. It seems inevitable that we are facing definitely inflationary trends. While we hope that the degree of inflation will be mild, nevertheless, in planning for our hospital of tomorrow, a sound purchasing policy is of greater importance than ever before. This is as true of the small hospital in which the administrator is responsible for the purchasing as it is in the larger institution with purchasing delegated to a person who is specifically trained in this field. If the hospital is to perform its function at all efficiently, it must exercise sound business management, and nothing contributes more to increased hospital costs than haphazard buying.

Now They Have Money

It is imperative that consideration be given to this problem now. For perhaps the first time in their history, many institutions are enjoying the jingle of money in their pockets. Many hospitals are limping along on old and carefully treasured equipment and consequently have accumulated a reserve fund, simply because they could not spend the money. This dammed-up purchasing power presents a grave problem.

The immensity of this problem will require the best thought and coordinated effort of all concerned. The administrator should be prepared to answer these questions: What are future plans? How much money will be available? What new equipment is needed? What is the likelihood of new and improved products? When and how will controls be relaxed? What will be the policy relative to allocation of materials to hospitals? These are questions that must be considered by each individual hospital.

Quality in supplies is still the primary consideration, despite the fact that the scarcity of the war years has tended to make almost anything acceptable and has perhaps blunted one's former sense of values. Quality means reliability, durability and satisfaction. Seemingly attractive price

labels on goods of inferior quality may be misleading. Now, if ever, is the time to take heed of the old adage, "Caveat emptor."

The old policy of purchasing from reliable firms is still a good one. It is from them that one may expect to get value received. It isn't a bad rule to trade on reputation, if it is the reputation of the dealer. And it is still advisable to confine one's purchases to a relatively small number of firms, those on which one has depended in the past and which have proved satisfactory.

Conditions of the past few years have practically thrown competitive buying into the discard. We have taken what we could get where we could get it. Whether the next few years will see much of a change is problematical. If ever there comes an end to priorities, W.P.B. and all the alphabetical agencies, it may be possible to indulge in competitive purchasing to advantage, especially in dealing with local firms.

Surplus war goods may serve as a source of supply to hospitals, although in what categories and amounts and through what channels, it is still impossible to state. Certain foods may be available, but it is rather doubtful if this will be of much importance to hospitals. Of greater concern is the matter of medical supplies, of which it is estimated that \$100,000,000 worth will be turned back to civilian use. It would seem only proper that much of this should be diverted for the use of hospitals. At any rate, the wise administrator will keep alive this possible source of supply, but again with a weather eye to the matter of quality.

While seemingly there have been few bright spots in purchasing in the

past few years, if we are to be honest with ourselves we must admit that we have learned a few valuable lessons. We have learned that we can do with less frequent purchasing and delivery. We have learned that we can use certain satisfactory and economical substitutes not even contemplated in the prewar days. We have learned the material value of conserving supplies and equipment. We have gained a better appreciation of quality. And last, we have come to see that we may enhance our purchasing power through wise and conscientious salvage. These lessons should not be discarded but should be incorporated in the purchasing policy of tomorrow.

Inventories May Be Revised

Some revision of inventory policy might be in order for the hospital of tomorrow. Of necessity, hospitals have carried an inventory considerably in excess of prewar days. Now we should begin to think of adjusting inventory to conditions of production and transportation, bearing in mind that top-heavy inventory lowers the value of the purchasing dollar. In a paper on this subject in 1941,¹ I quoted Cartmell² as defining the ordering point as the amount which ordinarily would be needed to meet the average, or somewhat more than average, requirements during the time new stock is being procured. I also said that the quantity to be ordered depended upon several factors: the amount of money available, the rate of use, the availability of supplies, the probability of deterioration and obsolescence and the problem of storage. This will be

¹Fisher, Pearl R., Principles of Purchasing and Inventory in the Small Hospital, New England Hospital Assembly, March 1941.

²Cartmell, Madison, Stores and Materials Control. New York: Ronald Press Company, 1922.

From "Convention by Mail," New England Hospital Assembly, April 1945.

as true of the hospital of tomorrow as it was in 1941.

With the release of restriction on supplies, one might expect purchasing to become relatively easy. Actually, the reverse will be true if one is to buy wisely. New firms, new supersalesmen, new materials, many of which may prove disappointing, may enter into the hospital field. All these make it imperative that intelligence in purchasing be exercised to the greatest degree.

The superintendent of the small hospital has had to develop a certain skill in hospital purchasing. She has worked, in most instances, with a definitely limited budget which allowed little margin for error. She

bought cautiously, but perhaps not always to best advantage. Now it becomes increasingly important that she become familiar with and use the many valuable aids to good purchasing, such as the Manual of Specifications of the American Hospital Association, *The Hospital Yearbook*, the various hospital journals and the releases of the Educational Buyers' Association. These will prove invaluable in establishing one's purchasing policy. I might also suggest that an efficient and well-conducted bureau could do much to ensure better value for money spent and certainly would be of much assistance to the superintendent who must be responsible for hospital purchasing.

Coordination Is Still to Come

COORDINATION or "regionalization," as the British call it, of hospital service has not as yet become a sufficiently clear-cut issue for many small hospitals to have an opinion. That conclusion is forced upon us by the fact that only seven administrators of the 50 who were queried completed a schedule on this subject.

Of the seven respondents only one reported any service now being received from the larger hospitals in the area. This is a home for chronic disease patients which uses free clinic services at a city hospital.

Thirteen specific possibilities for assistance to smaller hospitals were listed in the questionnaire. The hos-

pitals were asked if they would like to have assistance in any of these ways. Only two services, namely, accounting and business management counsel and clinical laboratory service, received as many as four votes. The votes on the other items were as follows (the chronic disease home did not vote on any):

X-ray interpretation and supervision	3
Medical library assistance	3
Electrocardiographic consultation	3
General administrative counsel	3
Training of nurse attendants	3
Traveling dietetic service	2
Postgraduate education fellowships for technicians	2
Plant and engineering counsel	2

Affiliation for graduate nursing in special fields	1
Assistance in locating personnel	1
Staff conferences and consultations in surgery, medicine and obstetrics	0
Postgraduate education fellowships for staff doctors	0
Group diagnostic service for difficult cases	0

Probably, if more hospitals had replied there would have been some that would have wanted all of these services, including the last three which failed to score in this particular poll. It is interesting to see that administrators themselves, in filling out this questionnaire, are ready to acknowledge the need of assistance in certain administrative functions, such as accounting and business management and general administrative counsel. This indicates a commendable honesty about their own limitations and a desire to achieve higher standards.

The final question was: "What steps do you think should be taken to bring about better service in the smaller hospitals?" Not very much was volunteered on this subject, but some of the suggestions are well worth considering. They are:

Group get-togethers should be held for the office personnel and others for supervisors.

Hospital councils should be formed with regular meetings to discuss common problems of personnel, rates and other subjects.

Small hospitals should combine to employ full-time pathologists and other specialists whom they cannot afford individually.

All small hospitals should work toward winning approval of the American College of Surgeons.

The Small Hospital Forum should be continued. [There is no thought of stopping it.—Ed.]

Doubtless, the Commission on Hospital Care will have suggestions to present to the smaller hospitals on this subject of cooperation. As a result of its detailed studies of various hospitals it may see some gaps in the services of smaller hospitals that are not so apparent to the administrators themselves. In any event, both the commission and the hospital leaders in each state should study the results of this preliminary and incomplete inquiry to see what significance it holds for future plans of an integrated hospital system.

THANKS TO THESE CORRESPONDENTS

HOSPITAL	ADMINISTRATOR	BEDS
Alta Community Hospital, Alta, Iowa	Clara LeRena Larson	15
Colver Hospital, Colver, Pa.	A. D. Martin, M.D.	18
St. Luke's Hospital, Crosby, N. D.	Sister M. Cecelia, O.S.B.	40
Dearborn Industrial and General Hospital, Dearborn, Mich.	E. Irene Black	41
Decatur General Hospital, Decatur, Ala.	M. G. Hubbard	50
A. G. Rhodes Home, Atlanta, Ga.	Mrs. Ryburn G. Clay	50
Alamosa Community Hospital, Alamosa, Colo.	Leo W. Reifel	50

HEADLINE NEWS

Hold Hearings on Utilization of Doctors in Armed Forces

WASHINGTON, D. C.—Hearings were held before a Senate military affairs subcommittee July 11 to investigate the relative needs of the armed forces and the civilian population for the services of medical personnel. These and further hearings will be prosecuted in connection with Senator Downey's bill S.R. 134.

Members of the subcommittee of which Senator Downey is the chairman have contended that the Army is overstaffed with doctors whose return to civilian practice should be accelerated. Gen. Robert W. Berry, representing the War Department at the hearings, disclosed plans to release 7000 medical men by next May. He was unable to guarantee earlier demobilization of all of them, though he said some sort of priority might be worked out to hasten their return from Europe.

Senator Johnson of California has demanded the prompt release of the 7000 doctors and accused the Army of taking a leisurely attitude toward the problem. Testimony at the hearings revealed that the Army, Navy and Veterans Administration now have about 60,000 medical men as compared to 74,000 in active civilian practice.

On July 16 the War Department reported that approximately 900 Medical Corps officers have been relieved from the Army since January 1. Also, 1000 medical corps officers have been requisitioned from Europe for return to the United States to relieve the shortage of doctors in Army hospitals, to relieve doctors who have not had overseas service and to increase the rate of return of doctors to civilian practice. Certain specialists whose fields make them essential will be retained longer than physicians whose skills are in less demand.

House Gets Construction Bill

WASHINGTON, D. C.—A hospital construction bill (H. 3561), identical with the Hill-Burton S. 191, was introduced in the House June 23 by Mr. Priest, chairman of the House committee on public health. Though hearings have been held on S. 191, introduced in January, the bill has been quiescent since. The Hill-Burton Bill was referred to the Senate education and labor committee; the Priest Bill, to the House committee on interstate and foreign commerce.

Revised Priorities System Announced; Six Months' Transition Period to Be Allowed

By EVA ADAMS CROSS

WASHINGTON, D. C.—A revised and simplified priorities system leading to ultimate discontinuance of priorities assistance for virtually everything except military requirements as soon as war-supporting and essential civilian production no longer needs general help was announced June 30. There will be a six months' transition period from July 1 to December 31 for adjustment to the new system. Military requirements will have top priority but civilian business will generally operate both without production restrictions and without affirmative priorities assistance.

The new Priorities Regulation No. 29 outlines the procedures to be instituted gradually during the latter half of this year. There will also be changes in other W.P.B. orders and regulations and where any inconsistency arises between a W.P.B. regulation or order and PR 29, the latter will control unless the contrary is expressly stated.

Under the new system the present AA rating method and the Controlled Materials Plan will be discontinued at the end of 1945 and replaced by a system in which the AAA rating will still be assigned in emergencies but a new MM rating will be assigned by military agencies. W.P.B. itself will assign the MM rating only in cases where it is clearly necessary for the war effort or for requirements of similar urgency. During the transition period, the MM rating will be equivalent to AA-1. The AA ratings also will be retained for certain materials, such as textiles, if it is not practicable to adapt existing controls to the new system.

Beginning as soon as possible, the military services will assign the MM rating to orders and contracts placed during the transition period for deliveries during or after the transition period. They may also change existing orders with AA ratings to MM ratings if necessary to ensure delivery on schedule.

It is called to the attention of hospitals that W.P.B. will, if necessary, provide additional procedures to give priorities assistance for war-supporting or *highly essential civilian purposes*. These may be in the form of a new rating junior to the MM rating or in the form of some other procedure. Regulations for MRO supplies will remain in effect through the rest of the year. After that ratings will

generally not be given on a blanket basis.

PR 29 states that before Oct. 1, 1945, W.P.B. will cancel outstanding AA ratings calling for delivery after the end of 1945, wherever this can be done without interfering with war production or war-supporting activities. Details as to what ratings are canceled and how purchasers must unrate their orders will be announced later. However, if a purchaser has a rating for a delivery to be made in 1946, he may assume that the rating is still valid until Oct. 1, 1945, unless it is specifically canceled by a later regulation or other formal action of W.P.B.

Memorial Hospital Plans World's Largest Cancer Research Center

An appeal for funds totaling approximately \$7,000,000 is to be made by Memorial Hospital for the Treatment of Cancer and Allied Diseases, New York City, in order to accomplish its projected plan of making the institution the largest cancer center in the world.

When completed, the cancer center, which is to be international in scope, will cover an entire city block and will have a total of 600 beds.

The program embraces the following coordinated projects:

1. Enlargement of existing research laboratories, addition of new ones and a substantial increase in the present scientific research staff.

2. Establishment of a fund to provide four year cancer fellowships for the graduate training of qualified doctors as cancer specialists and to support the teaching of cancer prevention and control methods.

3. Enlargement and rearrangement of the existing hospital building to provide space for a total of 300 beds, to extend facilities for specialized treatment and to expand the present Strang Cancer Prevention Clinic.

4. Integrating the 300 bed Dr. James Ewing Hospital for Cancer, which New York City has contracted to build on Memorial Hospital grounds, with the educational, special treatment and research departments of the center.

The campaign organization is now being worked out and will be announced in the near future.

New Senate Bill Proposes Extending Social Security to Include Hospitalization

By EVA ADAMS CROSS

WASHINGTON, D. C.—Sen. Theodore F. Green introduced S. 1188 June 25 to extend the Social Security Act by providing hospital benefits. The bill would also extend the coverage of federal old-age and survivors' insurance; provide insurance benefits for disabled workers; provide special federal aid to states for public assistance; provide federal grants to states for general public assistance; provide federal grants to states for compensation for unemployment and temporary disability; amend the provisions for federal grants to states for old-age assistance, aid to dependent children and aid to the blind, and amend the Internal Revenue Code.

In introducing the bill, Senator Green said that his proposed legislation represented a feasible plan for immediate action without prejudicing other larger issues which are involved in the Wagner Bill. He has limited his proposal, he said, to those modifications and additions on which there may be fairly ready agreement.

All persons covered by the Social Security Act and their wives and dependent children under 18 years of age would be provided hospitalization benefits up to thirty days per year. This amount can be increased to sixty days under the bill if the funds are adequate. The care of tuberculosis and nervous and mental diseases is not covered after diagnosis as such. There are the usual list of accredited hospitals, a National Advisory

Hospital Benefits Council appointed by the Social Security Board from the professions and agencies concerned with the operation of hospitals and "other persons informed on the need for or provision of hospital services." It is purely advisory in character.

Payments are to be at the rate of not less than \$3 per day nor more than \$6 per day and may be made, apparently, either to the patient himself or "to such other individual, agency or institution as the board may prescribe."

One per cent of pay rolls is set aside in the hospital benefits fund.

The bill proposes a new federal-state arrangement in connection with the unemployment compensation system. The present unemployment insurance provisions would be replaced by a grant-in-aid system under which the federal government would meet half the amount spent by the state.

Senator Green called attention to the fact that he had not included in his bill any provision for hospital construction. He considered it a separate problem. "I am inclined to think," he said, "that if provision is made for paying hospital bills the necessary hospitals will be constructed in most places. If the Congress wishes to make special provision for hospital construction, there is a separate bill, the pending Hill-Burton bill, S. 191, on which hearings have already been held and action can readily be taken."

Rankin-Johnson Bill Seeks to Clarify Veterans' Care Laws

WASHINGTON, D. C.—A bill introduced in the House by Representative Rankin and in the Senate by Senator Johnson of Colorado would clarify the laws regarding care of veterans, set up a priority system for their care and authorize the administrator to contract with private hospitals and institutions for care of veterans with service-connected disabilities, for women veterans and for veterans residing in territories or possessions in which veterans' facilities are otherwise not available.

The priority system provides for care to veterans in the following order: (1) those with service-connected disabilities; (2) those with ninety days or more of military service with nonservice-con-

nected disabilities with preference given to those unable to meet the costs; (3) those with less than ninety days of service and with nonservice-connected disabilities to the extent that facilities available are not needed by the other two groups. Substantially the same system applies to domiciliary as to hospital care.

These bills were attacked at a hearing before a Senate subcommittee on July 18 by members of the American Legion as "an economy axe wielded against veterans." General Hines said that the bill would coordinate existing hospital laws, correct many inequities and should be passed.

Copies of the testimony of Col. John H. Baird, assistant medical director in charge of the neuropsychiatric division, in refutation of the articles by Albert Deutsch and of Col. Roy A. Woford on the article by Albert Maisel were received last month. Each official examined the statements in detail.

Plan Distribution of Surplus Hospital Goods at "Nominal Prices"

By EVA ADAMS CROSS

WASHINGTON, D. C.—A regulation to implement the policy of the Surplus Property Board to make available medical and hospital supplies to hospitals at nominal prices is being formulated, according to an official of the Surplus Property Board July 5. At a recent hearing before a Senate subcommittee, Governor Hurley said, "It is our intention to make available surplus medicine and supplies to hospitals throughout the United States at almost the cost of mailing or shipping."

A memorandum read at this same hearing by Edward Heller of the Surplus Property Board declared that the board will distribute at nominal prices all items particularly or generally suited to public health and education on the basis of need to all institutions in the country. All medical, hospital and pharmaceutical equipment will be centralized and then distributed at nominal prices in those areas where public health standards are lowest.

A newspaper's report that such medical and hospital supplies to be distributed would run around \$200,000,000 worth was characterized by the official as "somebody's guess—but a good one."

Congress Passes Authorization Bill for Community Facilities

WASHINGTON, D. C.—The authorization bill, H.R. 3278, to provide additional funds for community facilities (Lanham projects) was passed June 26. No funds are included for construction projects. The bill authorizes an increase of \$30,000,000 in the amount that may be appropriated, an increase of \$35,000,000 to be used for grants to localities for the maintenance and operation of service projects and an authorization to grant funds for new projects after June 30, 1945, until July 1, 1946.

The unallotted balance of funds under Title II for war public service projects as of June 30 is estimated to be about \$7,000,000. The unappropriated balance of current authorizations amounts to \$3,000,000. Thus, some \$40,000,000 will be available for war public service projects in the fiscal year 1946.

Hospital and other miscellaneous projects will be put on a three month basis in receiving allocations of federal funds so that, inasmuch as the bill is strictly a war measure, such allocations can be discontinued promptly with the ending of the war.

Propose Appointment of Advisers to President on Veterans' Care

By EVA ADAMS CROSS

WASHINGTON, D. C.—Introduced in the Senate June 25 was a bill authorizing the appointment of outstanding members of the medical and related professions to advise the President with respect to the formulation of programs to provide medical care and hospitalization for veterans.

The committee would be composed of persons distinguished in the professions of medicine, surgery, dentistry, hospital administration and nursing. Members would receive no compensation but they would be reimbursed for any traveling or other expenses incurred by them in the performance of such services.

"It is my opinion," said Senator White in introducing the bill for himself and Senator Shipstead, "that an advisory committee should be established and consulted about a hospitalization and medical-care program that can give to the veterans the very best hospital facilities and medical care that the best trained men of the medical profession can give them. There is not merely a matter of medical care and treatment involved but also the expert management of hospitals."

Pepper Bill Seeks Expansion of G.I. Educational Benefits

WASHINGTON, D. C.—The Pepper Bill introduced in the Senate June 20 to expand the educational benefits of the G.I. Bill of Rights would have a beneficial effect on the supply and distribution of medical, dental and other health personnel, Senator Pepper claimed. He was referring specifically to the clause in the proposed amendment that would grant qualified students in preprofessional or professional courses up to seven years of education.

Increasing the benefit period to seven years for qualified professional students would, Senator Pepper pointed out, provide medical and dental education for many veterans who would not otherwise be able to complete such courses.

The amendment would increase the dependency allowances for veterans obtaining education under the provisions of the present act, remove the distinction against veterans over 25 years of age, extend the maximum duration of the educational benefit and allow veterans to start schooling later than the current deadline of two years after discharge.

Hospital Rating for Textiles Now AA-3; Better Uniform Material Available

WASHINGTON, D. C.—The textile order, M-317A, was amended on July 12 to give an AA-3 rating to hospitals for many of their textile needs. A further amendment to raise this to an AA-2X has been requested and there is some belief that only an AA-1 will really meet the needs of hospitals.

Furthermore, the order was dated July 12, was published about July 16 and yet it contained deadlines for filing hospital requirements of July 20 for the third quarter and August 2 for the fourth quarter. Both of these dates passed before any substantial number of hospitals could hear about the order, obtain copies of the forms in quadruplicate, fill them out and file them with W.P.B. At least a month's extension was necessary to make the order of any practical use to hospitals.

Uniform manufacturers were generally pleased, meanwhile, with an order of July 6 granting Class C sheeting (56 by 56 count), jeans, combed broadcloth and combed poplin for use in making graduate and student nurses' uniforms. The only other material which the manufacturers had requested was bed sheeting with a count of 68 by 72 threads per inch.

Under this revised program manufacturers are expected to produce in the third quarter the following: 58,000 dozen graduate nurses' uniforms, 18,750

dozen graduate nurses' caps, 6458 dozen student nurses' colored uniforms, 3000 dozen student nurses' white uniforms, 7500 dozen student nurses' caps, 12,000 dozen student nurses' collars, 12,000 dozen pairs of student nurses' cuffs, 7200 dozen student nurses' aprons and 7200 dozen student nurses' bibs.

While this program is a great improvement over previous conditions, the supply is still so short that deliveries will not be prompt and hospitals should continue to anticipate their requirements by at least six months. Manufacturers paid tribute to the efforts of Russell Clark of the A.H.A. and Glenn Studebaker of W.P.B. in getting this program approved by the textile division of W.P.B.

Brig. Gen. Hines Urges Cabinet Rank for Veterans' Administrator

WASHINGTON, D. C.—Brig. Gen. Frank T. Hines, shortly to be succeeded by Gen. Omar N. Bradley as Administrator of Veterans Affairs, told the House veterans' committee on July 3 that the head of the Veterans Administration should be a member of the cabinet. General Hines also recommended a medical and attendants corps for the Veterans Administration with pay increases sufficient to attract the highest type of personnel.

A bill has been introduced authorizing the President to appoint General Bradley to the office of Administrator of Veterans Affairs without affecting his military status and perquisites. The bill stipulates, however, that in the performance of his duties as administrator, General Bradley would be subject to no supervision, control, restriction or prohibition (military or otherwise) other than would be operative with respect to him if he were in no way connected with the War Department.

Seek F.W.A. Funds for Hospitals

WASHINGTON, D. C.—A bill, S. 1192, introduced June 26 by Senator Fulbright, would authorize the completion by Lanham Act funds of hospital projects initiated by the Works Progress Administration and the Works Projects Administration. The bill authorizes the use of unobligated funds of F.W.A., not to exceed \$200,000, for the completion of hospital projects initiated by the two agencies no longer in existence.

Advance Funds for Postwar Public Works

WASHINGTON, D. C.—First federal advances to states and their political subdivisions for the blueprinting of non-federal postwar public works, approved June 25, included hospital projects. The advances were made from the \$17,500,000 fund appropriated by Congress under authority of Title V of the War Mobilization and Reconversion Act of 1944. These advances do not in any way commit the federal government to assist in the construction of public works planned with funds advanced.

The city of St. Louis, a municipal corporation, was among the first group to benefit and received an advance of \$34,000 for planning a hospital facility, the estimated total cost of which is \$1,100,000.

The money advanced is to be repaid without interest when funds become available to the applicants to construct the specific projects for which the advances were made.

A.M.A. Publishes Its 14 Point Program for Medical Service

A 14 point positive program for the extension of medical service was published by the American Medical Association on July 21. The program puts the association squarely behind the development of "hospitalization insurance" but does not specifically endorse Blue Cross plans as such. Support is given to better living conditions, preventive medicine, extension of services to indigent under voluntary insurance plans and surveys. Nothing is said about group practice. Federal aid is endorsed where needed.

The program in full is as follows:

1. Sustained production leading to better living conditions with improved housing, nutrition and sanitation which are fundamental to good health; we support progressive action toward achieving these objectives.

2. An extended program of disease prevention with the development or extension of organizations for public health service so that every part of our country will have such service, as rapidly as adequate personnel can be trained.

3. Increased hospitalization insurance on a voluntary basis.

4. The development in or extension to all localities of voluntary sickness insurance plans and provision for the extension of these plans to the needy under the principles already established by the American Medical Association.

5. The provision of hospitalization and medical care to the indigent by local authorities under voluntary hospital and sickness insurance plans.

6. A survey of each state by qualified individuals and agencies to establish the need for additional medical care.

7. Federal aid to states where definite need is demonstrated, to be administered by the proper local agencies of the states involved with the help and advice of the medical profession.

8. Extension of information on these plans to all the people with recognition that such voluntary programs need not involve increased taxation.

9. A continuous survey of all voluntary plans for hospitalization and illness to determine their adequacy in meeting needs and maintaining continuous improvement in the quality of medical service rendered.

10. Discharge of physicians from the armed services as rapidly as is consistent with the war effort in order to facilitate redistribution and relocation of physicians in areas needing physicians.

11. Increased availability of medical education to young men and women to provide a greater number of physicians for rural areas.

12. Postponement of consideration of revolutionary changes while 60,000 medical men are in the service voluntarily and while 12,000,000 men and women are in uniform to preserve the American democratic system of government.

13. Adoption of federal legislation to provide for adjustments in draft regulation which will permit students to prepare for and continue the study of medicine.

14. Study of postwar medical personnel requirements with special reference to the needs of the veterans' hospitals, the regular Army and Navy departments and the United States Public Health Service.

U.S.P.H.S. Reduces Maintenance Payments for Cadet Nurses

WASHINGTON, D. C.—Because of action by Congress, the U.S.P.H.S. has had to reduce the payments to nursing schools for the maintenance of cadet nurses for the first nine months from \$45 per month to \$35 per month, beginning July 1. Studies made by the service indicate that in many hospitals this amount is sufficient to compensate for the net costs.

Approximately 2000 Negro students enrolled in schools of nursing during the last twelve months, Dr. Thomas Parran announced on July 8. As of May 31 there were 4128 Negro student nurses in the corps.

A health program for student nurses was issued by the service on June 29. It was prepared by a committee under the direction of Dr. C. L. Williams, assistant

surgeon general, with George Bugbee as one of the consultants. The program gives a complete outline of the health facilities and services that should be provided for student nurses.

Navy Gives Maternity Care

WASHINGTON, D. C.—Since July 1 the Navy has offered maternity care at any naval hospital or dispensary, having suitable facilities, to members of the Women's Reserves of the Naval Reserve, the Marine Corps Reserve, the Coast Guard Reserve, Navy Nurse Corps and the Nurse Corps, Naval Reserve, who have been discharged from the service because of pregnancy. Eligible personnel will also receive out-patient postnatal care for as long as the medical officer in command considers necessary. Except for subsistence charges, the service is furnished without cost to the individual patient.

Strike Threatened at Emergency Hospital in Washington, D. C.

By EVA ADAMS CROSS

WASHINGTON, D. C.—A dispute over a wage demand between Emergency Hospital here and nonprofessional hospital employees, members of the A. F. of L. Building Service Employees International Union, has resulted in the threat of a strike since July 5. The employees involved in the strike have been urged by union officials to stay on the job pending certification of the case to the War Labor Board. Negotiations between the hospital and the union up to the time of the present difficulty had been proceeding under court order before the conciliation service of the Labor Department.

George A. Garrett, president of the board of directors of Emergency Hospital, said in part in a statement which he permitted *THE MODERN HOSPITAL* to use: "The Emergency Hospital's policy is to live up to its name. When a medical emergency arises, it does not first inquire into the financial background of the person in need but accepts all comers. Ability to pay comes second. Would you wish to see this policy reversed?"

"The hospital is now faced with a unionization demand that would make the cost of operation \$10,000 per month more than total revenue."

The attorney for the union declared that Emergency Hospital had for three years continued to thwart all attempts by the union to alleviate what he called "oppressive working conditions and substandard pay" through the orderly process of negotiations. The U. S. Supreme Court early this year refused to review the appeal of the hospital from the order by the federal circuit court of appeals directing it to comply with an N.L.R.B. order to bargain collectively with its employees.

Maternity-Child Care Program Proposed

WASHINGTON, D. C.—Complete maternity care at federal and state expense is proposed in a bill introduced July 26 by Senator Pepper and nine other senators. It would provide a ten year program of expanded federal-state maternal and child health services with an appropriation of \$100,000,000 for the first year.

In addition to the maternal care, the program would offer preventive, curative and corrective services for children and would expand the present medical program for crippled and other physically handicapped children.

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TRUSTEE FORUM

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The New Trustee Makes His Bow

RAYMOND P. SLOAN

RECENTLY, a man nationally known in industry, whose picture appears frequently in the financial pages of newspapers all over the country as the director of this organization and that, was elected to a hospital board. Few readers caught the item in the local papers. It was buried at the bottom of a column and never got any farther.

Yet the fact that this industrial leader has been appointed to a position where he will have a voice in establishing the policies of an institution world famous for its medical research means far more to the average man, woman and child than does his identification with the pulp and paper industry, the automobile market or any other mercantile interests.

Why should this be? What is wrong?

Value of Trusteeship Overlooked

The answer may be found in a lack of conception on the part of the public and some hospitals too, unfortunately, of the importance of hospital trusteeship or stewardship. The scale of public interest weighs more heavily in favor of financial dividends than dividends in public health. Public education is the only corrective measure and because of the increasing attention that is being placed upon public health problems, this would seem to be a propitious time to apply it.

The failure of the press to award equal space to the industrial and hospital appointees is no indictment of its journalistic judgment. It knows what holds the greatest appeal to its public. Any indictment lies within the hospital group for its disinterest or lack of aggressiveness in telling its own story and emphasizing the

The question, "How do other hospitals introduce the new trustee?" presented in the Question of the Month column in these pages last May, aroused so much interest among our readers that it now appears as a major article

responsibility that enjoins upon every man and woman who accepts a place on the governing boards of these voluntary institutions.

To the extent that the hospital recognizes the importance of appointing the new board member and properly inducting him into office the press is influenced and will help interpret such news. Too frequently, such ceremony is no ceremony at all but merely a perfunctory introduction attended by a brief news release with little if any attempt at interpretation.

The new board member should be properly inducted, if not for his own benefit for the benefit of the hospital he is to serve and the community he represents. Whether he recognizes it or not the hospital trustee is a public servant. Consequently, he and the public should each be made familiar with the respective responsibilities and obligations of the other.

Without any orientation to hospital surroundings and operation the newly elected trustee is distinctly at a disadvantage. Occasionally, he recognizes this lack and voluntarily seeks certain basic information. More frequently he drifts along, adding his "yes" or "no" to those of others who, he assumes, possess greater knowledge than he does.

Asa S. Bacon, veteran hospital administrator and superintendent

emeritus, Presbyterian Hospital, Chicago, tells of a telephone call he received a short time ago from a young business man who had been appointed to membership on the board of a certain prominent hospital. This young executive explained that he had been put on the house committee and was anxious to know what would be expected of him. He confessed he knew nothing about hospital operation or the duties of a trustee, but he wanted to learn.

This situation is typical. As Mr. Bacon puts it, "There are too few people in hospitals who are really familiar with their charter, constitution and by-laws and also the duties of their trustees. In many of our hospitals the employees seldom know a trustee when they see one."

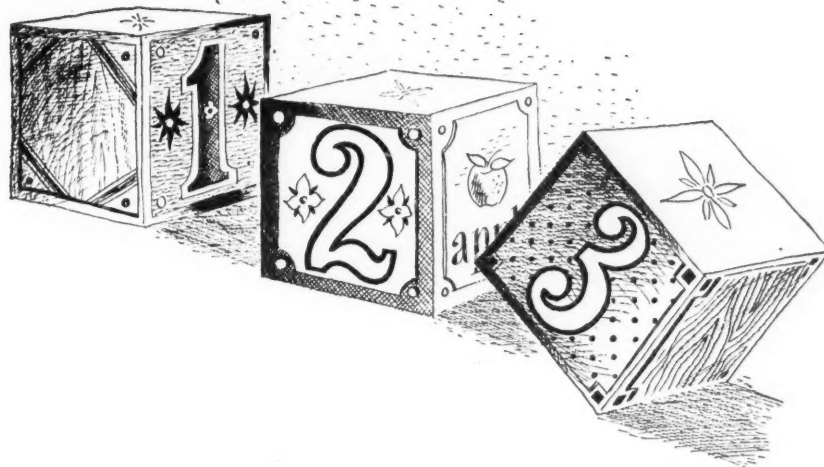
Here is Mr. Bacon's solution. The induction of every new member to a hospital board should be accompanied by suitable ceremonies. These should be held at the hospital with members of the board, heads of departments, members of the staff, the women's auxiliary and representatives of the press in attendance. A speaker should be invited who can explain the duties of a trustee and perhaps read the charter, constitution and by-laws.

"This," Mr. Bacon states, "not only will give the hospital family an opportunity to meet the new member and welcome him, but will furnish it with information that it, too, needs." He emphasizes the importance of including members of the press because of the benefits to the public relations program.

Make It a Real Occasion

The possibilities for making the induction of the new trustee a real occasion are great. Whether the ceremony assumes substantial proportions or is observed more modestly, certain introductions should be made and certain information should be furnished the new members. The press may or may not be present but complete data on the appointment, with photographs and the usual biographical material, should be prepared and released in advance.

Personal introductions to other members of the board, to the medical staff, to department heads, to the president of the volunteer group or auxiliary are requisite. Such introductions may take place at a formal reception or meeting or may be ac-



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completed during a tour of inspection around the hospital.

These are questions that can best be decided individually. The important objective is that the trustee know the executive heads of the institution for whose policies and standards he is responsible, also that they know him.

There is much to be said in favor of making such a ceremony a social occasion. It contributes to better personnel relations throughout.

Not only should the new trustee be properly introduced but he should be taken on a complete tour of the hospital property. It is not expected that he will obtain anything more than a general impression on his first trip but it will constitute a foundation, nevertheless, which can be developed as time goes on.

Get Them Off to a Good Start

Illustrative of the increasing tendency on the part of hospital officers and administrators to help the trustee get off to a proper start is the short memorandum that Dr. E. M. Bluestone, director, Montefiore Hospital for Chronic Diseases, New York, recently prepared for the president of that institution for use in the indoctrination process for new trustees. In this he covers the following 11 points:

1. The hospital itself; in this instance, Montefiore Hospital.
2. Participation at board meetings.
3. Selection of committees for specialized activity.
4. Cooperation with the office of the director.
5. Visits to the hospital and its branches.
6. Hospital literature (local and general).
7. Financial obligations to the hospital.
8. Public relations obligations.
9. Rigid impartiality in (a) the admitting office and (b) appointments to the professional and non-professional staffs.
10. Relation to the various charity chests and cooperating communal agencies.
11. When in doubt, apply to the president of the hospital or to the director for information.

Such an outline prepared to meet the individual requirements of the hospital should go far in giving the new trustee an insight into its operation and his part in it.

Effective suggestions for introducing the new member and making him feel at home might come, too, from those who have experienced the uncertainty of being injected into this strange and supposedly forbidding atmosphere. Why not, therefore, put the question directly to those trustees who now are completely initiated?

"What would have helped you most in orienting yourself to the hospital background? From your own experience what can be done to make it easy for the novice? What questions would you have liked to have had answered at the start?" To these questions we might well add: "What questions would you still like to have answered?"

These questions actually were asked in one hospital, on which occasion one of the younger members stated emphatically: "How well I remember the day of my debut. Because the average age of the group was considerably higher than my own I was scared stiff. It happened at one of the regular board meetings and out of a membership of some 35 only 15 were present.

"The president, a most impressive gentleman, made the announcement of my appointment and proceeded to recite among my qualifications those of my revered father and grandfather, both of whom had rendered such valuable service to the institution. 'Surely,' he added, 'we can ask no more of our youngest appointee than that he follow in those estimable footsteps. Will he now stand up so that we all can have a look at him?'"

"That was my introduction into hospital work," this trustee went on. "Based on my own experience, therefore, I would heartily endorse any helpful information that might be passed along to the new board member that will give him some idea not only of what is to be expected of him but also of some of the problems that are peculiar to hospital operation which makes them different from business problems. In other words, treat him like an average human being who has something to offer on his own. Give him a job promptly and help him perform it efficiently."

Following this declaration, which would seem fairly typical, general discussion followed in which all manner of startling revelations were

disclosed. Among other discoveries was the fact that several members of the board had never met certain doctors on the staff.

Then and there a list of suggested helps for the new trustee was compiled which would assure him an excellent foundation for service. At the same time it was unanimously agreed that in future each new trustee should be suitably honored by an informal reception to which all key people would be invited; also, that this event should be publicized.

It is recommended that other hospital groups follow this example. The trend is evident. No longer will the newly elected member of a hospital board stand up, make his bow and sit down. He will stand up, shake hands with his associates and proceed to go to work, knowing precisely what is expected of him and how he can fulfill those expectations.

Question of the Month

QUESTION: Our hospital has grown from a small institution and we retain too much the methods of control that were used 40 years ago. We are anxious to find the best practices in the matter of (1) independent annual audit and (2) what employees and officers, by title, should be bonded.—W.J.A.

ANSWER: 1. It is essential that a hospital have an independent annual audit. In fact, it is recommended that monthly audits be made by an outside auditing firm and, also, that the audits be accomplished by accountants who are familiar with hospital practices, because their suggestions concerning the handling of the many funds in the hospital are most helpful.

2. A so-called comprehensive 3-D policy is recommended which insures against (a) loss through dishonesty of employees; (b) loss of money and securities within the premises; (c) damage to premises and equipment caused by robbery or attempt thereat, and (d) loss of money and securities outside the premises.

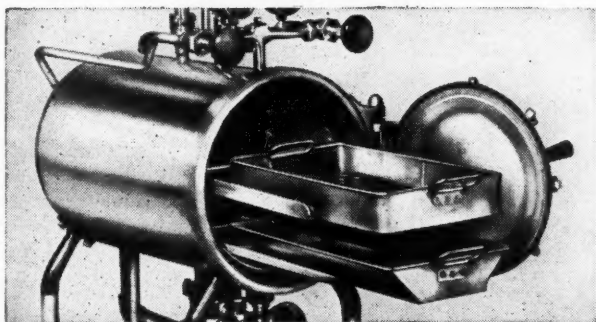
This type of bond covers all officers and employees and divides the employees into different classifications according to their responsibilities. The premium is based on the number of employees in each class, the amount of the fidelity bond and the maximum amount of cash and/or negotiable securities kept in the safe or in transit for deposit. Most surety companies write this form of bond. It is urged that the amount of the bond be substantial.—W.J.D.

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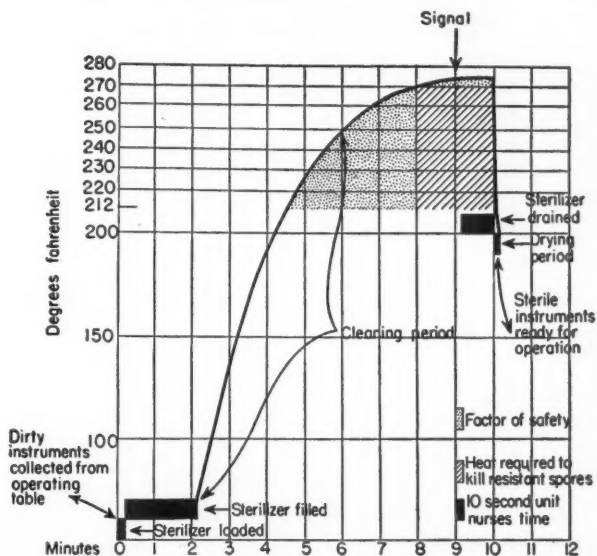
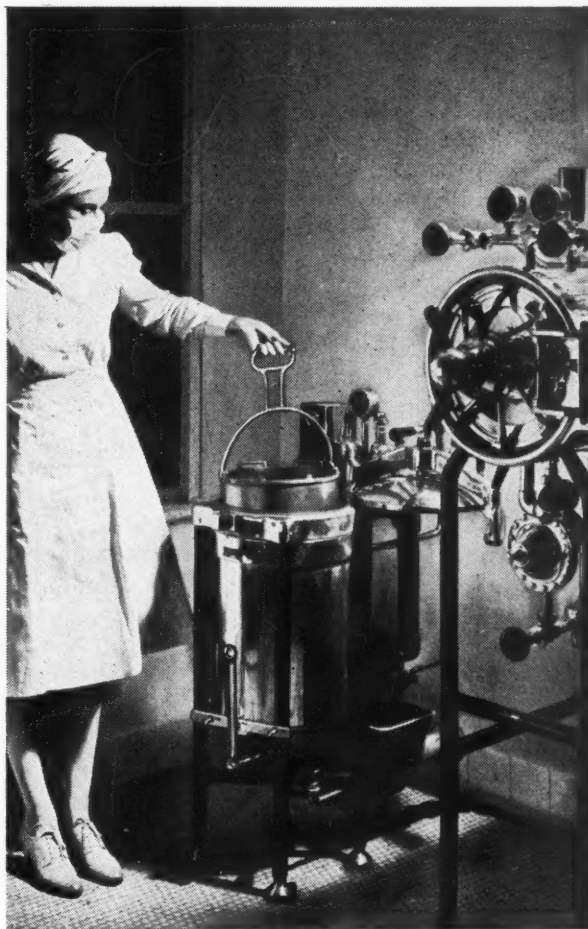


Chart shows time and temperature during a normal operation of the Instrument Washer-Sterilizer.



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STERILIZERS AND LIGHTS

Trends in Modern Anesthesia

JOHN ADRIANI, M.D.

Director
Department of Anesthesia
Charity Hospital, New Orleans

IN THE last fifteen years, many advances have been made in anesthesiology. Not only have new drugs and technics been added but a better understanding of the physiologic changes accompanying anesthesia has developed.

Anesthesia may be classed according to the routes of administration of the drugs employed. Four types that are important in clinical surgery are inhalation, intravenous, rectal and regional.

Inhalation Anesthesia.—In inhalation anesthesia only gases or vapors of highly volatile liquids are satisfactory agents. Three gases of importance are nitrous oxide, ethylene and cyclopropane. Nitrous oxide and ethylene are satisfactory for superficial operations. Neither, however, yields sufficient muscular relaxation for major surgery. Cyclopropane, on the other hand, is potent and yields any depth of surgical anesthesia desired.

Suboxygenation Dangerous

High concentrations of nitrous oxide or ethylene are necessary in the lungs (75 to 85 per cent) for surgical anesthesia. Unless patients are premedicated with morphine, suboxygenation frequently is necessary to obtain anesthesia. Accidents due to asphyxia are common and permanent damage to the brain may result if the patient survives. If anesthesia cannot be obtained without suboxygenation, ether should be added to the mixture so that more oxygen may be used.

Suboxygenation is not a problem when cyclopropane is used because the concentration for surgical anesthesia is low (20 to 30 per cent). Adequate oxygenation is assured because the remainder of the inhaled mixture may be oxygen.

Rapid induction and recovery are features common to all three gases. Unconsciousness results within two

or three minutes. Recovery from nitrous oxide and ethylene is equally rapid. A somewhat longer recovery is required for cyclopropane anesthesia. With the exception of cyclopropane, which disturbs the heart, gases cause little or no systemic effects if there is no suboxygenation. They are nonirritating and therefore are ideal for acute or chronic diseases of the respiratory system. No significant changes are noted in the function of the liver, the kidney or in the chemical constituents of the blood.

Suboxygenation, however, causes rises in blood pressure and changes in heart rhythm, an elevation in blood sugar, increase in acidity of the blood and disturbances of liver and kidney functions. Cyclopropane should be avoided in patients with heart disease. Epinephrine, if used simultaneously with cyclopropane, seriously affects the heart and may cause sudden death.

Nitrous oxide is a noninflammable inorganic gas. Ethylene and cyclopropane are hydrocarbons which form explosive mixtures with air, oxygen or nitrous oxide. Nitrous oxide supports combustion because it readily parts with the oxygen in its molecule.

The currently employed volatile liquids include ether, vinethene, chloroform and ethyl chloride. Vinethene is a recent addition to the list of drugs; the others are well established. The vapor concentrations of all four drugs necessary for surgical anesthesia are considerably lower than are those of the gases, less than 5 per cent. Adequate oxygenation is thus assured.

Chloroform and ether provide adequate muscular relaxation for major surgery; ethyl chloride and vinethene do not. These vapors are irritating

to the mucous membranes of the respiratory tract. Secretion of mucus is common unless abolished by atropine or scopolamine administered preliminary to anesthesia. Inflammatory diseases of the respiratory tract are usually aggravated by these drugs.

Ether and vinethene do not affect the circulatory system. Ether, contrary to popular belief, is not contraindicated if heart disease is present. Disturbances in rhythm are not common and are usually not serious if they occur. The deleterious effects of chloroform on the heart are a matter of common knowledge. Ethyl chloride is similar to chloroform and, like chloroform, is contraindicated if heart disease is present. In fact, there is little justification for using either of these two drugs. Chloroform is scarcely used in present day anesthesia except for analgesia.

Blood Chemical Changes

Volatile drugs cause notable blood chemical changes. Sugar levels are elevated and the blood acidity is increased. Liver and kidney function is disturbed. Liver damage often follows chloroform anesthesia, particularly if accompanied by suboxygenation.

Induction time is rapid with vinethene, ethyl chloride and chloroform but slow with ether. Induction with ether is slow for two reasons: (1) it is irritating and (2) it is necessary to have high concentration at the beginning to saturate the blood. Both ether and chloroform are eliminated slowly. Recovery, therefore, is slow. Induction by the drop method, even by skilled persons, may take fifteen minutes.

Induction is simplified and shortened by first anesthetizing the patient with nitrous oxide, ethylene, cyclopropane or other rapid acting nonirritating drugs. Higher concentrations of ether may be inhaled at



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the outset. Ethyl chloride, which is often used as a preliminary to open ether, is objectionable because of its effects on the heart. Vinethene, which is equally rapid and effective, does not affect the heart. It is far safer and should replace ethyl chloride for this purpose.

With the exception of chloroform, these vapors are inflammable and possess the same explosion hazard as the gases. Chloroform vapor is also undesirable, however, because it may be converted to phosgene if exposed to flames, sparks or cautery.

One desirable feature of inhalation anesthesia is that it is controllable. Concentrations may be gradually increased or decreased so that depth is varied at will. The drug is easily eliminated by artificial respiration when overdosage occurs. Inhalation agents are chemically inert in the body and are eliminated unchanged through the lungs.

Machines are necessary for administration of gaseous drugs. Volatile liquids may be administered by open methods or by machine. Open methods are simple because air is used as the diluent and the source of oxygen. Moreover, they dispense with elaborate equipment.

Gases require a source of concentrated oxygen. Closed system machines designed for rebreathing are superior to all other types because an even level of anesthesia and a better physiologic control of oxygen and carbon dioxide concentration are allowed. The enclosure of gas mixtures in tight-fitting inhalers reduces costs and minimizes the explosion hazards.

Open Methods Wasteful

Open methods of vaporization, while safer in inexperienced hands, are objectionable because they are wasteful, yield an uneven level of anesthesia and often interfere with carbon dioxide elimination and cause suboxygenation and lowering of body temperature.

The explosion hazard is one of the objectionable features of inhalation anesthesia. Humidification of operating rooms, grounding, use of spark-proof electrical equipment, the rebreathing technic, use of quenching agents, such as helium, nitrogen and the Horton intercoupler, have minimized the danger but not eliminated it. The Horton intercoupler is designed to prevent sparks caused by

static electricity. It interconnects the patient, operating table, ground, anesthesia machine and anesthetist to a resistance so that the electrical potential is equalized in these bodies. Static discharges account for the majority of anesthetic explosions.

Intravenous Anesthesia. — Intravenous anesthesia has been developed since the introduction of the short-acting barbiturates. Although many barbiturates are known, two are used clinically for intravenous anesthesia, evipal and pentothal. Both produce an intense action over a short period of time. Intravenous anesthesia is not controllable, that is, once a given dosage has been administered, it cannot be retrieved. Reliance is placed solely upon the mechanisms of detoxification or upon the use of stimulants to reverse the action.

Intravenous anesthesia should be limited to short minor surgical procedures in healthy subjects. The simplicity of this technic of anesthesia, unfortunately, often places intravenous anesthesia in the hands of individuals who are unfamiliar with the management of anesthesia complications. It also encourages the administration of anesthetics and performance of surgery under circumstances and in places in which its use is not judicious.

The technic, perhaps inadvertently, is frequently selected from the standpoint of convenience to the operator rather than of safety of the patient. Susceptibility to the drug varies with each individual. Estimation of dosage is not standardized as yet. Recovery in short procedures is prompt by virtue of the supposed rapid detoxification of these drugs in tissues.

A prolonged, undesired, postanesthesia somnolence often accompanies the administration of large amounts of the drug in long surgical procedures because there is a cumulative action. Depth of anesthesia is not as easily judged because the criteria used for inhalation anesthesia are not applicable to these drugs. Coughing, stridor, sneezing and laryngeal spasms occur frequently because reflexes in the throat, trachea and lungs are not abolished. Attempts of inexperienced individuals to abolish these reflexes completely often lead to overdosage.

A marked depression of respiration is common during and after intravenous anesthesia. Acute or chronic diseases of the respiratory system, dis-

eases of the heart, the extremes of age, anemias, toxemias, metabolic diseases and liver diseases are contraindications to intravenous anesthesia.

Rectal Anesthesia. — Rectal anesthesia is not as popular today as it was a number of years ago. Few drugs are satisfactory for rectal anesthesia. The tri-halogenated ethyl alcohols are the most satisfactory available drugs. The most widely employed drug is avertin, which is tribromethanol dissolved in amylene hydrate. Trichlorethanol is similar to avertin and a more recent addition. Trichlorethanol is not as satisfactory as avertin and, in the opinion of some, not as safe.

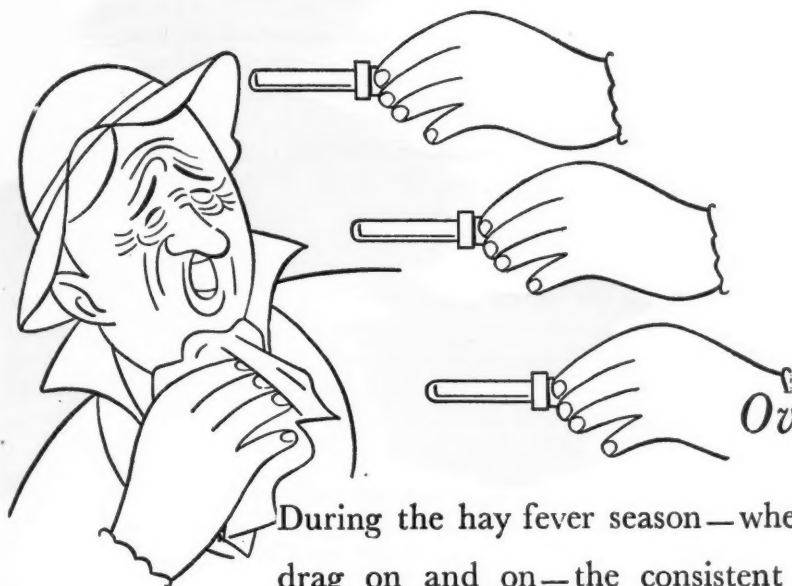
Ten minutes after the administration of avertin, a deep hypnosis appears which lasts several hours. However, reflexes in the larynx and pharynx are not abolished. In addition, the patient is aroused by pain stimuli and the use of a supplemental inhalation or local anesthetic is necessary to abolish reflexes completely. Inasmuch as complete anesthesia is not obtained, the narcosis is often referred to as "basal anesthesia."

Depression of respiration and a fall in systolic blood pressure are objectionable side actions. Avertin is detoxified by the liver. The drug is contraindicated in heart diseases, respiratory diseases, diabetes, shock, liver and kidney diseases and in rectal or colonic operations.

Avertin is useful in psychically disturbed individuals and in convulsive states, such as tetanus. It is popular in neurosurgery because it causes no increase in intracranial pressure.

Regional Anesthesia. — Regional anesthesia has for many years been conducted almost exclusively with procaine (novocaine). Recently, newer drugs have been introduced. Metycaine, pontocaine, nupercaine, intracaine and monocaine are some of the most useful. Regional anesthesia is employed in psychically suited subjects in whom inhalation and other types of anesthesia either are not desired or are contraindicated.

Metycaine and monocaine are used for infiltration or for such nerve blocks as caudal, cervical and brachial. Novocaine, pontocaine, monocaine, metycaine and nupercaine are used for spinal anesthesia. Spinal anesthesia if not properly induced and carefully supervised is far from



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safe. However, improvement in technic and a better understanding of the physiologic changes that accompany it have increased the safety factor.

The muscular relaxation it yields is difficult to duplicate by any other technic. This feature and the fact that the anesthesia can be induced by a member of the operating team tempt the surgeon to use it routinely and often in patients who should not have it.

The extent of anesthesia is important. In "high spinal" it extends above the ribs. In "low spinal" it is confined below the diaphragm. "High spinal" is dangerous. Death from spinal anesthesia is usually the result of one of two complications. The first of these, and the one that occurs more frequently, is a fall in blood pressure. Vasoconstrictor drugs, such as ephedrine and neosynephrine, effectively combat this circulatory collapse in good risk patients. In poor risk patients, these drugs are not always effective and the patient dies from "shock."

Circulatory disturbances occur consistently in the presence of anemia, shock, diseases of the heart and blood vessels, hypertension, hypotension and arteriosclerosis. Any drug or procedure that insults the circulatory system, as does spinal anesthesia, is obviously contraindicated when this system is diseased.

The second serious complication is respiratory failure caused by allowing anesthesia to extend too high so that the muscles of the chest and diaphragm become paralyzed. If recognized immediately, the patient can be saved by giving artificial respiration until the paralysis wears off. All spinal and local anesthetics should be watched every minute of the time by a trained anesthetist. Oxygen and resuscitation equipment should be in readiness during every spinal.

Unfortunately, the effect of most drugs used for regional anesthesia lasts little less than an hour. This duration of action is not long enough for most surgical procedures. This has been overcome in spinal anesthesia by the use of longer-acting drugs, or by continuous spinal anesthesia. Pontocaine, for example, yields anesthesia for approximately two to two and a half hours, while the effects of nupercaine last from three to four hours.

In continuous spinal anesthesia, a malleable needle is left in the patient's spinal canal throughout the operation. This is accomplished by the use of a specially elevated mattress with a recess that protects the needle. When the anesthesia wears off, another dose is injected. More recently, the technic has been simplified by using a fine catheter instead of the needle. The cumbersome mattress and the needle are thereby eliminated.

The principles underlying continuous spinal anesthesia have been applied to caudal anesthesia. In caudal anesthesia, a local anesthetic drug is injected at the base of the spine where the lowermost nerves emerge. Continuous caudal anesthesia, although widely popularized, possesses all the drawbacks of ordinary caudal in addition to those of the continuous technic. When administered and supervised by a skilled anesthetist,

caudal anesthesia has a place in medical practice but it is far from ideal.

Certain nonvolatile substances used in conjunction with anesthesia have appeared in the last four or five years. One of these, intocostin, is a highly purified form of curare. Curare is a drug that paralyzes the nerve endings as they enter the muscle. If administered with general anesthesia, the amount of anesthetic is reduced and the muscles are relaxed. The use of curare preparations by inexperienced persons is dangerous. The drug should only be used by physicians who are familiar with its pharmacologic action.

Another new drug used in anesthesia is demerol. This preparation is a substitute for morphine and may be used when morphine cannot. It is not as effective and is not preferable to morphine as a preliminary to surgery. Furthermore, demerol is also habit forming.

Developments in Antibiotics

FREDRICK F. YONKMAN, M.D.

Lafayette Park, Summit, N. J.

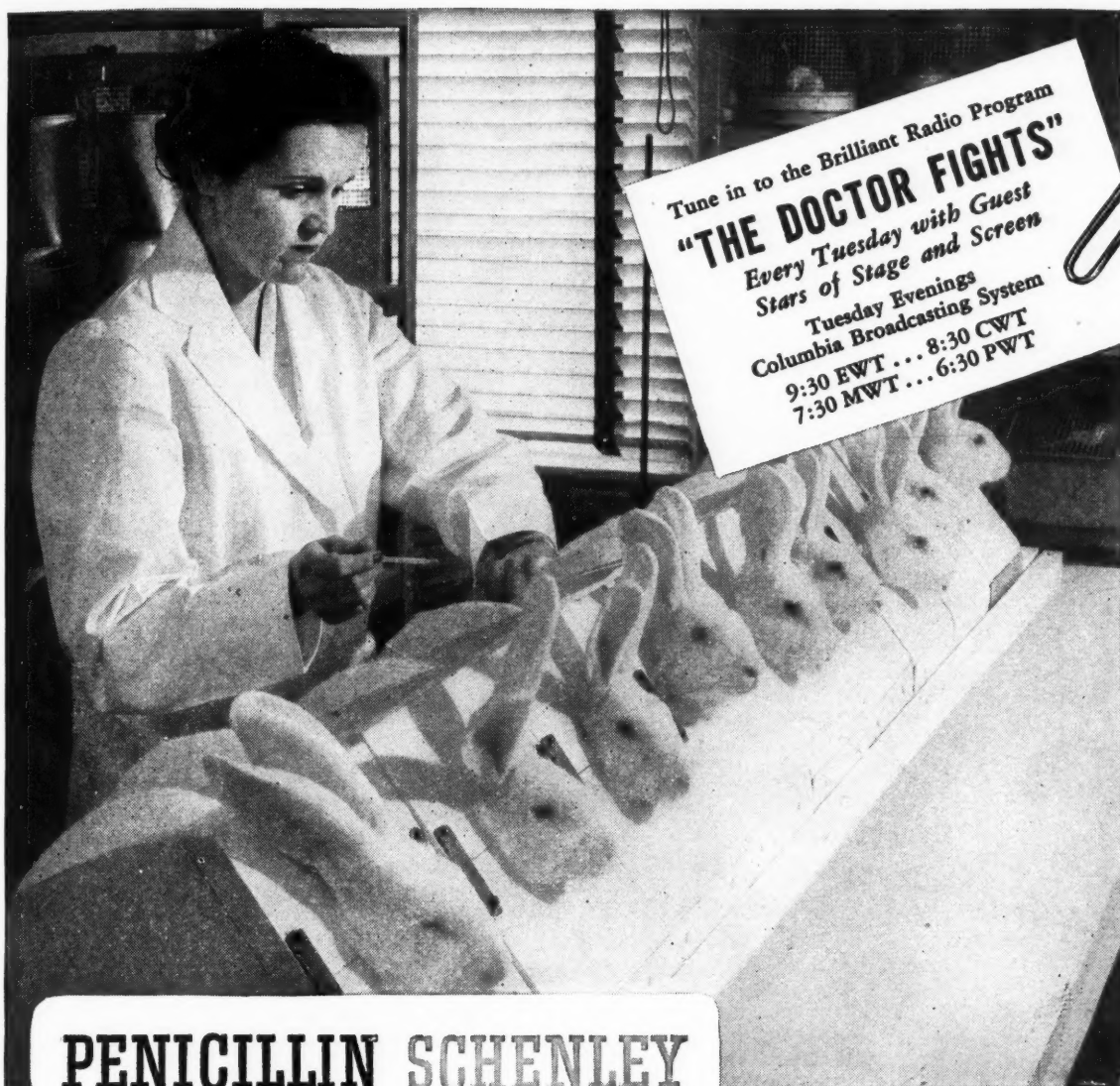
SINCE Sir Alexander Fleming's discovery of *Penicillium notatum*'s capacity of inhibiting the growth of *Staphylococcus aureus* and other organisms, an entirely new field of bacteriologic, pharmacologic and clinical investigation has blossomed into fruition of varied types. Not only have advances been made in the direction of improving penicillin and of widening its horizons but new antibiotics have appeared and are already in experimental use in the clinics. It is with some of these recent advances that this article is concerned.

Penicillin. The history of penicillin is not only fascinating but challenging. It demonstrates what can be done by way of well-directed cooperative research in which the laboratory investigator and clinician cooperate under university auspices; it also demonstrates how proper assistance from industry in several of its capacities can contribute to the rapid transfer of a promising laboratory observation into one of science's most valuable contributions to the general welfare of mankind. It is a far cry from early expensive crude penicillin to the sterilized, inexpensive

ampule of the purified material now available at the corner pharmacy.

Herrell in his recent and excellent book, "Penicillin and Other Antibiotic Agents," tells a humorous incident involving the early days of penicillin development in England. It seems that Doctor Florey, one of Fleming's co-workers, was studying with his group the pharmacology of penicillin in one of his patients who happened to be a member of the Oxford police force. These investigators learned that about 60 per cent of a dose administered to the patient appeared rather early as such in the urine and, if extracted and purified, could be used again with value for further treatment of the patient.

At about the same time Doctor Florey's group was having considerable difficulty in supplying the demands of its own clinic with penicillin developed in the culture laboratories. The workers graduated from flasks and bottles finally to bedpans in order to produce larger quantities more readily. When a certain fellow faculty member at Oxford University heard of Doctor Florey's work and of the difficulties en-



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countered, he admonished his medical students to learn more about "this wonderful drug which is purported to be grown in bedpans and purified by passage through the Oxford Police Force!"

Many more tales, and as interesting, could be told; these would include the heartaches experienced by physicians and loved ones because of the lack of adequate supplies in the early days of penicillin.

Because of its importance and its dearth, numerous attempts were made to "spare" penicillin by one means or another. These included, among others, the following:

1. Delaying its excretion by the kidney by diodrast administered simultaneously.

2. Delaying its excretion by the kidney by simultaneous administration of para-aminohippuric acid.

3. Delaying absorption at the site of injection of penicillin by: (a) addition of beeswax or gelatin; (b) addition of vasoconstrictors; (c) addition of vasoconstrictors in beeswax or gelatin; (d) addition of oil; (e) addition of vasoconstrictors in oil, and (f) application of ice packs to site of injection to afford vasoconstriction.

4. Protection against stomach acidity

after oral administration by: (a) use of a duodenal tube; (b) adding various oils and milk or cream; (c) buffering with colloidal aluminum hydroxide and trisodium citrate; (d) administering concentrated solutions in several 1 or 2 cc. amounts to permit absorption from the oral pharyngeal and esophageal mucosa before the remainder of 1 or 2 cc. amounts arrives in the stomach (by this means 100,000 units can apparently be given orally in two or three successive 1 or 2 cc. amounts within fifteen to twenty minutes or thereabouts, which seems most feasible and convenient), and (e) incorporation in rectal suppositories.

5. Inhalation directly into the very vascular pulmonary bed in the form of a mist or spray.

6. Administration of penicillin directly into an infected area, such as the cerebro-spinal canal, empyema pockets or draining sinuses.

While all of these excellent contributions were being made by various medical investigators, industry had set its sights on increased production. The most recent production and cost price figures available have been supplied by Van Winkle and Herwick (*Journal of the American Pharmaceutical Association*) and these details are most gratifying:

"According to War Production Board figures, approximately four hundred million units of penicillin were produced during the first five months of 1943. The total production for 1943 was approximately 22 billion units; for 1944, 1600 billion units, and in January 1945, 394 billion units were produced in that month alone, increasing in June to an estimated 650 billion units. The price of penicillin was \$20 per hundred thousand units in July 1943. In January 1945, the average price was approximately \$2.40 for the same amount."

Since the appearance of these figures, the cost of penicillin has again been reduced to 95 cents for 100,000 units, a dose which constitutes frequently an adequate amount for a mild or moderate infection. The eventual cost to the consumer of this valuable drug will undoubtedly be determined by the capacity of industry to increase still more the already considerable production of this antibiotic. What synthetic production of penicillin will do to costs is still problematic but there seems to be no question that industry has succeeded in giving to American medicine the most valuable drug in its experience and with the least expense to the patient.

Gramicidin and Tyrocidine. These antibiotics, which were obtained from soil bacteria by Du Bos and his colleagues at the Rockefeller Institute,

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represent other valuable contributions to this field of therapy. Because of their toxic properties systemically they are restricted to only local application in certain infections. Because of this fact and penicillin's inability to combat all types of infections, continued search for other antibiotics was mandatory. These searchings gave to us numerous other agents of this type, some of which offer definite promise in certain infections as yet untouched by naturally occurring antibiotic substances.

Streptothricin. This substance was obtained from a mold, *Actinomyces lavendulae*, by Waksman's group

(1941) at Rutgers University. It is a highly active agent and has been experimentally demonstrated to be of value in infections caused by *E. Coli*, *B. abortus*, *B. subtilis*, *Salmonella paratyphi A* and *B*, *Eberthella typhi* and certain pathogenic fungi, including *Blastomyces dermatitidis*. Unfortunately, such infections as tetanus and that caused by the gas bacillus are resistant to the actions of streptothricin. This agent is therefore promising in certain respects from a clinical point of view but definitely limited in others.

Streptomycin. This antibiotic was also developed by Waksman's group

(1944) and is normally obtained by culturing another mold, *Actinomyces griseus*. It possesses certain properties not characteristic of those of streptothricin, and notable among these one finds its lethal or bacteriostatic action against *E. Coli*, *Mycobacterium tuberculosis*, *Salmonella schottmülleri*, *Pseudomonas aeruginosa*, fowl typhoid, *Brucella abortus*, *Proteus vulgaris* and other bacteria of lesser importance.

The results obtained with streptomycin by Feldman and Hinshaw at Rochester, Minn., in experimental tuberculosis in guinea pigs are of considerable interest. In their publication (*Proc. Staff. Meet.*, Mayo Clinic, Dec. 27, 1944) a tabulation indicates that in two groups of animals studied the results were as follows:

<i>Number of Animals Index of Infection</i>	
Group 1	
Controls 8	81.9
Treated 4	2.8
Group 2	
Controls 9	67.0
Treated 9	5.8

One is impressed with these results which seem to offer much in tuberculosis. If this valuable drug can be still further improved, particularly if it can be purified to such an extent that toxic side reactions are eradicated without sacrifice of its antituberculosis properties, the treatment of human and bovine tuberculosis by safe chemotherapeutic agents may be a goal not too far from early attainment.

And with so many of man's common infections gradually being brought under protection by scientific appropriation of "nature's nuggets" in one form or another, who dares to predict the future of man's experience in this enterprise?

Is it too much to hope or even to anticipate that one of our most serious afflictions; cancer, may still lend itself to control by some antibiotic or enzyme accelerator or inhibitory mechanisms? Foolhardy may be he who so predicts, yet remorseful may eventually be the one whose skepticism dampens his own enthusiasm and scientific enterprise.

CLINICAL BRIEFS

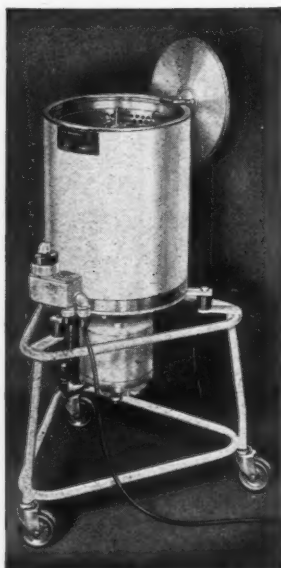
Conducted by E. M. Bluestone, M.D.

Bed Rest Theory Modified

From time immemorial, our methods of living, thinking or doing things can be traced to some dictum inherited from our past. This seems to be especially true of therapeutic measures taken for the care of the sick. Most frequently the method is amplified or modified to such an extent that a com-

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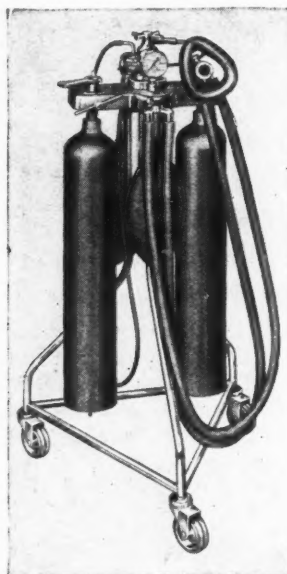


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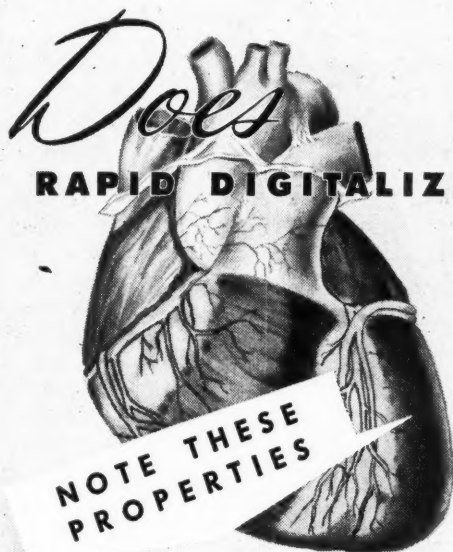
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parison of present practices with those of the past finds no similarity and the basic reason for the procedure is entirely lost. This may be aptly applied to the problem of rest *vs.* activity as a therapeutic measure, which has been reviewed editorially in the *Proc. Staff Meetings of the Mayo Clinic* 20 (6): 90-95, 1945, under the title, "The Abuse of Rest as a Therapeutic Agent."

The recommendation for rest in the treatment of the sick has probably had more exponents than has any other therapeutic measure. The recommendations of such prominent medical leaders as Weir, Mitchell, Thomas and

Krause carried enough prestige to influence the thought and action of all men of medicine in America.

While Mitchell's conception of nervous exhaustion, nervous fatigue, fatigue neuroses and neurasthenia indicated to him the need for a rest cure, the extent to which this procedure was carried by others who followed him makes the remedy seem ridiculous in the light of modern physiological knowledge. Possibly the basis for Mitchell's rest cure in psychiatry seems now to lack the reason for its present day practice. In the modern trend, Menninger* contends that the rest treatment for neuroses is

unsound both in theory and in practice.

Like Mitchell in psychiatry, Thomas' influence on orthopedists held sway for many years and the therapeutic value of rest in this branch of medicine has been overemphasized. The pendulum is beginning in the opposite direction in this field, too, for Ghormley* writes that prolonged and complete rest in bed in orthopedic cases has had detrimental effects. The old and often repeated admonition for rest in tuberculosis has been gradually modified to include carefully graded activity.

The reaction to rest therapy has spread to other branches of medicine. In cardiovascular diseases (Harrison*), rest measures which were invariably prescribed are now considered in many cases unsound, for death ensues from complications induced frequently by this form of therapy. In obstetrics (Eastman*) and in surgery (Powers*), rest has been limited, as in cardiovascular disease, to the active stages. Dock* points out that bed rest is frequently followed by such disturbances as bone atrophy, muscular wasting and vasomotor instability while constipation, cathartic habituation, backache and many other chronic disabilities may appear during bed rest and persist afterward.

Dock summarizes the new thought on rest therapy as follows: "The physician must always consider complete bed rest as a highly unphysiologic and definitely hazardous form of therapy to be ordered only for specific indications and discontinued as early as possible."

—MICHAEL LEVINE.

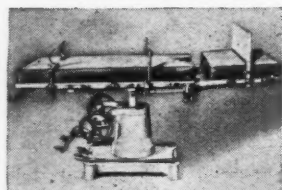
*Journal of the A.M.A., Aug. 19, 1944.

Symposium on Diabetes

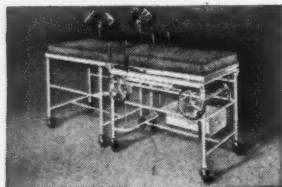
In a symposium of articles embracing the subject of diabetes mellitus as observed in 100 cases for ten or more years, R. Richardson and M. A. Bowie write under the title of "General Observations," J. Edeiken writes under the title of "Cardiac Studies," I. H. Leopold writes under the title of "Ocular Findings" and M. Naide writes under the title of "Peripheral Vascular Findings" in 89 of these cases, in the *American Journal of Medical Science* 209 (1): 1-28, 1945.

This series of papers presents a comprehensive view of the subject in which the heart, eyes and peripheral circulation of the patients were studied in relation to this disease. These patients were under close dietary supervision during which period the carbohydrate intake had been increased and the fat decreased. They were studied first in the metabolic clinic and later in other clinics.

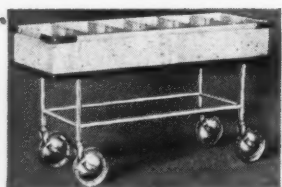
The report of the metabolic clinic deals with the nutrient intake of these



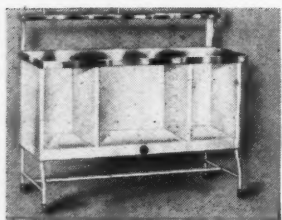
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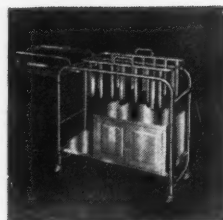
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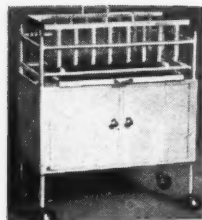
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patients over a period of fifteen years. In that time the fat content varied from 70 to 110 gm. daily; the carbohydrate intake was between 125 and 200 gm., while the proteins had been increased to a little over 70 gm. daily.

The patients were classified according to race into three groups, viz. Negro, Jewish and others. Patients' ages varied from the second decade of life to the eighth; the largest number were in the 50 to 70 group. Men comprised 25 per cent and women the remainder. Seventy-four members of this group had diabetes for more than ten years. The smaller group (26 per cent)

had the disease for only ten years. An effort was made to maintain the patient's weight slightly below normal for height, sex and age. Nevertheless, 18 patients attained weights above normal. Acidosis with coma was experienced by 26 of the patients before they came to the clinic and only three had this experience during the ten year period studied.

The severity of the diabetic condition was determined on the basis of insulin required for control. Accordingly, the patients were arranged into four groups. The first group consisted of patients who required no insulin; the second re-

quired 25 units daily; the third was taking 25 to 50 units; the fourth group was given 50 or more units daily. The effectiveness of the control measures was determined by blood sugar examinations. While these patients presented all degrees of diabetes, 60 per cent of them maintained blood sugar under levels 180 mgm.; only 8 per cent showed poor adjustments.

The author concluded that the duration factor in diabetes has no relation to its severity or to the success with which the patient maintains control. Improvement or changes made by the patient after a four year period were based on the study of two separate years. In some patients there was an improvement in the diabetes while in others the improvement came from a better adjustment with increased use of insulin. Infections, syphilis, tuberculosis, arteriosclerosis, thyroid, kidney, liver and gall bladder conditions appeared in these patients.

The cardiovascular status of these diabetics showed hypertension in 38 per cent of the cases. These patients were in the fifth, or higher, decade of the age groups and the incidence increased with the increase in age and was more common in women than in men. The hypertension however was not definitely dependent upon the duration, control or severity of the disease. Cardiac enlargement was present in 10 of 38 cases with hypertension. The greatest degree of cardiac enlargement was observed in three cases with myocardial abnormality. Only three patients under 50 years of age had cardiac abnormalities attributable to their diabetic state. This significant observation may be attributed, the author believes, to the high-carbohydrate low-fat diet.

The ophthalmological investigation carried out in these patients showed clearly, the author believes, that controlled therapy reduced the incidence of corneal wrinkles, iritis, muscle palsies, optic neuritis, optic atrophy and the senile type of lens changes. Complicated cataracts appeared to be more abundant in nontreated than in treated cases. Superficial hemorrhage, as well as deep retinal hemorrhages and exudates, was directly related to the duration factor.

Of the 100 cases of diabetes, 89 with the disease for periods of ten to twenty-five years were studied for arteriosclerotic occlusion in the legs. Three patients under 50 years of age and 30 over 50 years of age had peripheral arteriosclerosis. Premature arteriosclerosis was not common in this group of patients. The severity factor had no effect on the incidence of arteriosclerosis. In general, the adequately controlled patients showed little arterial disease.—MICHAEL LEVINE.

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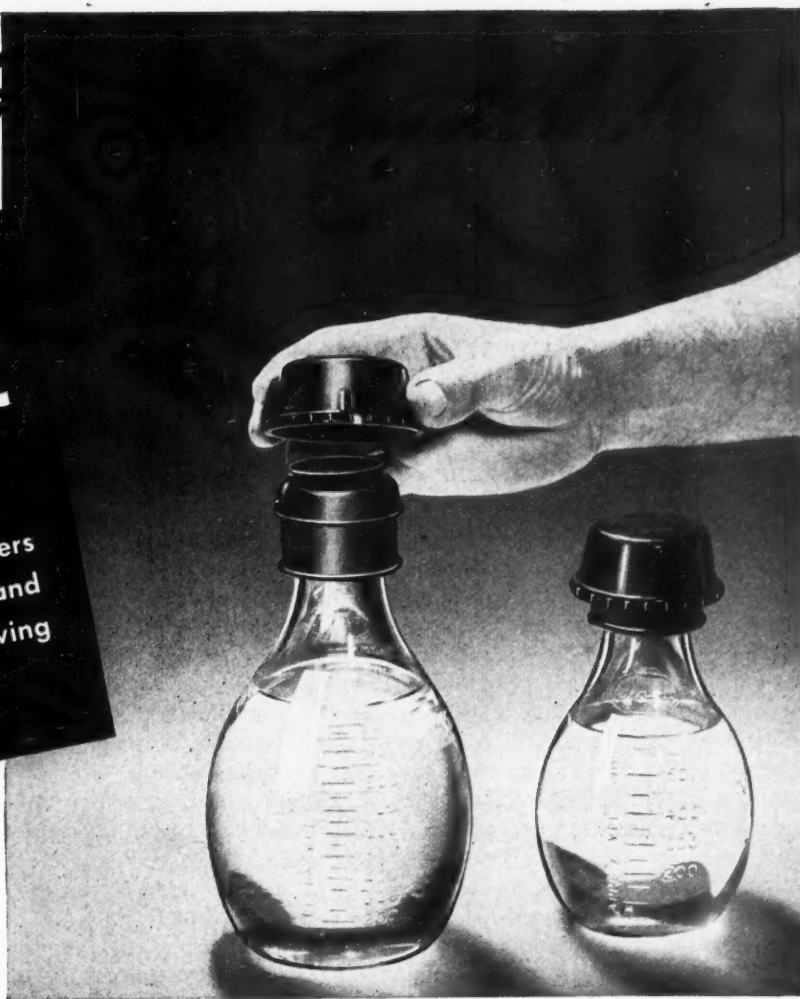
<input type="checkbox"/> MA	Neuroanatomy	Photomicrographs
<input type="checkbox"/> MB	Bacteriology	Photomicrographs, colonies, cultures, clinical photographs
<input type="checkbox"/> MC	Communicable Diseases	Clinical photographs
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243 Broadway Cambridge, Massachusetts

Normal Nutrition Is Our Goal

SOPHIA HEENDS AND STEPHEN MANHEIMER, M.D.

Former Nutritionist and Present Director, Respectively
Mount Sinai Hospital, Chicago

NOT many hospitals of our size (235 beds) have a full-time nutrition service for clinic patients. Prior to December 1943, Mount Sinai Hospital, Chicago, had a part-time service directed toward clinic patients referred for special diets. Obviously, the nutritionist's contacts with patients were few. Diabetic patients returned to the clinic to see the doctor but many did not receive any dietary instructions for two or more years. Their diabetic conditions were, therefore, difficult to control.

Well aware of the inadequacy of such dietary treatment, the administration decided in late 1943 to take a progressive step in this field of medical service. The new clinic service was introduced to the medical staff by means of letters from the hospital director, by presenting the nutritionist personally to staff members and by extending personal invi-

tations to the physicians to listen in on group discussions with patients.

The nutritionist is now in contact with all patients receiving diet therapy. Records are reviewed by her and interviews are arranged with patients who are under dietary treatment. This method was used to initiate referrals of patients by the doctors, because the service was not developed and the doctors had not been conditioned to nutritionist consultation. Diabetic patients are now seen at regular intervals by the nutritionist individually and in group discussions. As a result of this close supervision, the patients are more familiar with their diets and their illness is better controlled.

Patients who are on reducing diets are seen weekly. They are weighed and their diets are reviewed. The weekly food records kept by them are brought in for discussion. These

patients feel the need of close supervision of their diets and constant encouragement, without which there would be little or no improvement. Every patient registered in the prenatal clinic is now referred routinely to the nutritionist for a normal pregnancy diet or, if some complications exist, for a special diet.

Groups of patients are taught normal nutrition, while they wait for the doctor, from charts, posters and by means of wax food models. In view of the lack of space for group instruction one of the waiting rooms is used as a classroom. These patients have shown considerable interest in these discussions. The question of the value of group instruction *vs.* individual instruction is one that always presents itself. It is obvious that the results of individual instruction can better be observed than can those of group instruction. Obviously, the personal contact with the patient has its advantages.

The age of the patient is a factor in evaluating the method of instruction. Learning is necessarily slower with advancing age. At the present time there are more patients in the older age bracket attending the clinic than formerly. In Mount Sinai clinic, 75 per cent of the patients receiving dietary treatment are between the ages of 50 and 80, 36 per cent of this group being in the fifties. That leaves the larger percentage of the patients in the 60 to 80 age group. Therefore, any great degree of success in group instruction for these patients is doubtful, whereas individual dietary instruction might be more valuable.

A certain degree of success in group instruction has been achieved with diabetic patients as a whole. This was evidenced especially during the Passover holiday week. It is a known fact that either these patients do not know how to substitute the special Passover foods for the other foods or that they eat more than they should at this time. As a result, Jewish diabetic patients generally



Seventy-five per cent of the clinic patients are between 50 and 80.

become uncontrolled during this period.

Acknowledging this fact, the nutritionist started an intensive period of group instruction to these patients on every diabetic clinic day two months before the holiday week. Much interest was aroused since these patients knew from past experience that following this holiday their illness was often aggravated. As a result of the instruction the patients were much better controlled and only a small percentage came in with complications.

In addition to the continual instruction in diet, copies of the diabetic diets have been translated into Yiddish for those who do not read English. The doctors, as well as the patients, felt that a definite need had been met by these translated diet lists.

The clinic medical staff has welcomed the nutrition service wholeheartedly. As one doctor has said, "The service is meeting a medical need as necessary as the laboratory or the doctor himself in the medical care of the out-patients." One of the doctors who has been on the clinic staff for twelve years strongly objected for years to the lack of adequate dietetic service to patients in the clinic. He is most enthusiastic about the inclusion of the services of a nutritionist in the clinic. The medical staff is more and more availing itself of this important clinic service.

Nutritionist and social worker cooperate in joint planning with patients in helping them plan their budgets more carefully. The nutritionist has brought situations to the attention of the social worker where social factors militate against adequately following the recommendations. It is planned that home visits by social worker and nutritionist will be made in those situations where such a visit might be of value in working out a better program.

There is much more to be done to make the service still more valuable. In view of the fact that the greater proportion of the patients served by the nutritionist in this clinic are in the older age group, better nutrition for the aged and the aging can be and is now being effected. It is known that symptoms attributed to senile debility may be due to malnutrition and to unbalanced diets. It is planned to concen-

trate on this phase of nutrition to help "add life to years rather than years to life," thereby increasing the patients' period of usefulness.

It is also hoped that more work can be done with children in the future. When more space is available, group meetings with children will be held and the scope of educational work with this age group will be broadened.

Contacts with the clinic staff physicians must be continued in order to increase the number of referrals by them to the nutritionist, thus improving the nutrition service to the patient.

The work of the nutritionist service and the dietetics department of the hospital is carried out under the direction of Regina Gottlieb, the supervising dietitian.

Suggestions for Those Sunday Suppers

FROM a Michigan dietitian recently came this plaintive plea: "What do other hospitals serve for supper, especially for Sunday night supper when the kitchen staff is in a rush to get through work? We have had cold cuts for two years, so please don't suggest that!"

Well, Miss Michigan, you can unfurrow that pretty brow for we have broadcast your plight to several other hospital dietitians and, despite their heavy war-time activity load, they have responded magnificently. They have the same problem, most of them admit, but they are passing on the menus that are favorites in their institutions. We shall publish all of them in the hope that our respondents may be repaid in kind.

MARGERY CASE, Cortland County Hospital, Cortland, N. Y.

For Sunday night suppers we have found a favored menu to consist of the following combinations:

Soup: Vegetable, cream of celery, mushroom or tomato.

Salad Plate: Fruit salad, molded fruit salad or frozen fruit salad; cottage cheese, nut bread and jam, or cream cheese and fruit-nut bread sandwiches.

Dessert: Cake, cooky or ice cream.
Beverage.

This menu also finds favor with the employes as it requires more beforehand preparation and less last minute work.

VIRGINIA BECKER, Lutheran Hospital, Cleveland

Here are a few suggested menus for light Sunday suppers:

Oyster stew
Fresh fruit salad plate
Cottage cheese
Muffins *Jelly*
Assorted cookies
Coffee, tea, milk
•
Chicken-rice soup
Fresh shrimp salad
Potato chips *Radish rose garnish*
Peanut butter cookies
Coffee, tea, milk
•
Cream of mushroom soup
Toasted bacon-tomato on lettuce
sandwiches with mayonnaise
Dill pickle chips
Chocolate cake
Coffee, tea, milk

FLO IRWIN, John Gaston Hospital, Memphis, Tenn.

Here are some of the favorite menus used in our hospital staff dining room. The patients' menus are derived from these with the necessary modifications.

Toasted tomato, bacon and cheese sandwich
Potato chips
Tossed vegetable salad
Deep dish apple pie
•
Sliced cheese and bacon strips
Tomato on lettuce
Potato salad
Vanilla ice cream

Thick vegetable salad
Cream cheese and cucumber sandwich
Pick-up salad
Jelly filled doughnuts

•
Scrambled eggs on fried bologna
Rhode Island potatoes
Congeaed carrot and pineapple salad
Graham cracker pudding

•
Asparagus on toast with cheese
sauce and bacon
Tomato aspic salad
Iced chocolate cake

Our favorite recipe for cream cheese and cucumber sandwich spread follows.

Sandwich Spread
Yield: 100 Sandwiches
 1 pound cream cheese
 1 cup grated cucumber
 4 cups mayonnaise
 Salt, few grains

ELIZABETH STEWART, Good Samaritan Hospital, Portland, Ore.

Sunday night suppers are a problem. I hope the following suggestions will prove useful.

Vegetable chowder
Sliced tomato, cottage cheese
salad plate
Hot cornbread or rolls (may be purchased)
Fresh or canned fruits

•
Oyster stew or clam chowder
Peanut butter sandwiches with
fruit salad plate
Simple cakes or cookies

•
Cream soup
Meat pie with carrots and celery
Green salad
Brownies Butterscotch pudding

•
Cream soup
Italianne spaghetti
Bread sticks
Vegetable salad
Fruit gelatin

•
Cream soup
Potato salad plate with
sliced cheese
Vegetable
Fresh, canned or frozen fruit

•
Meat stock soup
Crab (or meat) salad plate
Hot rolls or bread (may be purchased)
Vegetable
Simple cake or pudding

Meat stock soup
Toast with creamed American cheese
and bacon strips
Vegetable
Sliced tomato salad
Fresh, canned or frozen fruit

HORTENSE VIRKLER, Highland Hospital, Rochester, N. Y.

The following list of supper dishes and menus cannot all be served at this time. However, they can be modified very satisfactorily. Some of our favorite recipes are also given in the next column.

Cream soup
Bacon roll, toasted Potato chips
Relishes Chef's salad
Fresh fruit Cookies

•
Cream of tomato soup
Layer sandwich
Olives, Celery hearts and
Potato chips
Sliced orange salad garnished
with mint
Chocolate cake with boiled icing

•
Cream soup
Fresh frozen crabmeat salad on
lettuce
Potato chips
Olives Sweet gherkins
Half hard cooked egg
Sliced tomatoes
Home-made hot rolls
Lemon sherbet Butterscotch brownies

•
Oyster stew or clam chowder (frozen)
Large fresh fruit salad (oranges,
grapefruit, pineapple, bananas,
garnished with berries when in season)
Home-made nut bread and cream
cheese with chopped maraschino cherry
Pudding or cake

Other favorite supper dishes with us are chipped beef à la mode; Welsh rabbit or tomato rabbit on crackers or melba toast served with molded Waldorf salad or gingerale salad; fresh asparagus tips on toast with cheese sauce garnished with two strips of bacon when available (gingerale salad is excellent with this dish); tomato favorite sandwich; scrambled eggs, melba toast, sausage; macaroni and cheese with fresh asparagus; Spanish rice; baked omelet with fresh mushrooms (sauce or broiled).

For the nurses' cafeteria or employes: Highland Special with molded salad; wieners baked in chili sauce; chopped luncheon meat mixed with chopped mustard pickle spread on toasted bun.

Chipped Beet à la Mode

Yield: 200 Servings

12 lbs. fresh mushrooms
 4 cups butter
 6 cups flour
 12 qts. milk
 8 lbs. American cheese
 4 cups chopped pimiento
 8 lbs. chipped beef
 8 lbs. medium noodles
 8 cups buttered crumbs

Cook mushrooms in butter five minutes. Blend in flour. Add milk gradually. Cook until thickened. Add shredded cheese and cook until melted. Add pimiento, chipped beef and noodles, which have been well cooked and thoroughly drained. Place in pans and cover with crumbs. Brown.

NOTE: A smaller amount of chipped beef can be used satisfactorily.

Layer Sandwiches

Yield: 16 servings per loaf

Egg salad
 Tuna, mackerel or chicken salad
 Pimiento cheese

Cut 2 pound pullman bread in six slices lengthwise after crusts have been removed. Starting at the bottom of the loaf fill successive layers as follows: bread, egg salad, bread, cheese, bread, tuna salad, bread, cheese, bread, egg salad, bread. Cover entire loaf with cream cheese and set in refrigerator for two or three hours.

Gingerale Salad

Yield: 150 Servings

2 cans lemon gelatin
 2 2/3 qts. boiling water
 1 cup sugar
 5 qts. gingerale

Mix the foregoing ingredients and let cool. When they begin to congeal, add:

1 1/3 qts. broken nut meats
 1 1/3 qts. diced pineapple
 1 1/3 qts. orange sections
 1 1/3 qts. Royal Anne or Bing cherries
 1 1/3 qts. maraschino cherries
 Pour into pans and let stand until set.

Tomato Favorite Sandwich

20 slices of toast
 20 tomatoes, medium
 1/2 cup butter
 2 lbs. American cheese
 1 pt. milk
 40 slices bacon

On each slice of toast place a tomato that has been peeled and baked in a slow oven. (Baste with butter while baking.) Slowly melt the cheese in the top of a double boiler. Add the milk gradually, stirring constantly until sauce is smooth. Over each portion of tomato and toast, pour a generous amount of hot cheese sauce. Garnish each serving with two strips of crisp broiled bacon and a sprig of parsley.



Accepted...

AND SO WELL TOLERATED

During the course of acute infectious diseases and following surgery, maintenance of the nutritional state is frequently a problem. The poor appetite which characteristically develops, taxes the ingenuity of the dietitians and nursing staff. Yet nutritional needs must be satisfied to insure maximum progress and rapid recovery.

By making Ovaltine available in the hospital, many feeding problems are readily solved. This delicious food drink, made with milk as directed, provides a wealth of essential nutrients

as indicated by the table below. Its delightful taste is enjoyed by all patients, young and old. It injects welcome variety into meals, encouraging consumption of other foodstuffs. Ovaltine is thoroughly bland, hence is tolerated without difficulty; it evokes no epigastric or lower abdominal distress. In consequence, it finds great usefulness immediately after surgery, during acute illnesses, and in the course of convalescence. It is especially valuable in the pediatric and maternity sections.

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Ovaltine

Three daily servings of Ovaltine, each made of ½ oz. Ovaltine and 8 oz. of whole milk,* provide:

PROTEIN	31.2 Gm.	VITAMIN A	2953 I.U.
CARBOHYDRATE	62.43 Gm.	VITAMIN D	480 I.U.
FAT	29.34 Gm.	THIAMINE	1.296 mg.
CALCIUM	1.104 Gm.	RIBOFLAVIN	1.278 mg.
PHOSPHORUS	.903 Gm.	NIACIN	7.0 mg.
IRON	11.94 mg.	COPPER	.5 mg.

*Based on average reported values for milk.

Highland Special

Rye bread
White meat of chicken
Sliced ham
Cabbage, shredded
Sliced yellow cheese
Russian dressing

Place two slices of rye bread on luncheon plate. On each slice place slices of white chicken meat, slice of ham and slice of cheese. In the middle of the two slices, place shredded cabbage. Pour a generous helping of Russian dressing on the cabbage.

NOTE: This is a prewar menu. Now we serve luncheon meat instead of ham.

MARY ELIZABETH DONAHUE, Good Samaritan Hospital, Cincinnati

The second administrative assistant at Good Samaritan has the following suggestions for supper menus:

Duchess soup
Deviled eggs and sliced cheese
Potato salad
Tomato quarters
Fruit cup with mint

Vegetable soup
Cottage cheese *Broiled tomatoes*
Peach salad with cherry gelatin
Lemon lime cake

Broth with noodles
Broiled peach halves stuffed with cottage cheese and strawberry preserves
Assorted relishes
Tea cakes

French onion soup
Cold roast beef
Buttered peas and carrots
Potato chip salad
Frosted cherries

Duchess soup
Scrambled eggs with mushrooms
Buttered green beans
Raw vegetable salad
Chocolate malted milk cake with frosting

Duchess soup
Sliced ham sandwich on rye with lettuce
Hot vinaigrette potatoes
Molded sunshine salad
Frosted purple plums

Turkey soup
Cold sliced tongue, chili sauce
Baked sweet potatoes
Coleslaw
Chocolate cake with marshmallow frosting

Lakeside soup
Meat spread sandwich with lettuce
Potato chips *Pickled peaches*
Pound cake with toasted pecans

Duchess soup
Maurice salad (chicken and ham)
French fried potatoes
Tomato quarters
Orange dainties

Turkey soup
Denver eggs *Stewed tomatoes*
Spiced spears
Chocolate fudge cake

Lakeside soup
Cold roast pork *Potato salad*
Assorted relishes
Peach halves

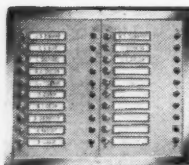
Soup
Bacon *Corn pudding*
Head lettuce with green goddess dressing
Emperor grapes



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CANNON ELECTRIC

CANNON ELECTRIC DEVELOPMENT COMPANY, LOS ANGELES, CALIFORNIA



Duchess and Lakeside soups are repeated frequently in these menus as chicken stock is usually available from Sunday dinner menu. Both soups are quite popular at our hospital.

Our potato chip salad is made of potato chips, celery, hard cooked eggs, sweet pickles and onion combined with mayonnaise.

ORANGE JUICE

CONDENSED—ADD WATER AND SERVE

GREEN SPOT vacuum condenses at low temperature the juice of selected tree-ripened oranges within 24 hours of the time the fruit is picked, retaining the maximum amount of natural Vitamin C.

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RECEIVED March 28, 1945

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Standardized with Sugar.
Composite sample from four different lots
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TOTAL SOLIDS by Evaporation:-

PROTEIN:-

CITRIC ACID (Free, as anhydrous):-

PECTIN:-

ASH:-

CARBOHYDRATES (by difference):-

POTASSIUM:-

CALCIUM:-

PHOSPHORUS:-

SPECIFIC GRAVITY:- 20° C./ 20° C.:-

ASCORBIC ACID, Milligrams per gram:-

OR INTERNATIONAL UNITS OF VITAMIN "C" per gram

CALORIES per gram:-

(*) Calculated values for product when reconstituted as directed, which approximates the tests of average Orange Juice as squeezed from the fruit

DETERMINATIONS

CONDENSED	RECONSTITUTED (*)
69.33 %	13.86 %
2.63	0.53
4.55	0.91
0.42	0.08
2.11	0.42
59.62	11.92
1.125	0.245
0.026	0.005
0.072	0.014
1.35016	1.05615
2.37	0.44
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BY: Erwin H. Miller

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Menus for September 1945

Imogene C. Chaney
Shannon West Texas Memorial Hospital
San Angelo, Tex.

- | | | | | | |
|---|--|--|--|--|--|
| <p>1
Orange Halves
Scrambled Eggs, Bacon
•
Roast Beef and Gravy
Escalloped Potatoes
Green Beans
Tossed Vegetable Salad
White Cake, Chocolate
Icing
•
Cream of Tomato Soup,
Crackers
Broiled Lamb Chops,
Mint Jelly
Parsley Potatoes
Grated Carrot and Peanut
Salad
Fruit Gelatin</p> | <p>2
Grapefruit Juice
Bacon, Sweet Rolls
•
Broiled Chicken
Mashed Potatoes
Asparagus, Hollandaise
Sauce
Pineapple, Cottage Cheese
Salad
Ice Cream, Chocolate
Sauce
•
Vegetable Soup, Crackers
Cold Roast Lamb
Baked Potatoes
Tomato Salad
Applesauce, Cookies</p> | <p>3
Stewed Prunes
Scrambled Eggs
•
Swiss Steak
Buttered Corn
Harvard Beets
Wilted Lettuce
Peach Cobbler
•
Cream of Pea Soup,
Crackers
Broiled Sweetbreads
Buttered Rice
Melon Ball Salad
Bread Pudding</p> | <p>4
Grapefruit Halves
Bacon, Toast
•
Broiled Liver
Spaghetti and Tomatoes
Buttered Peas
Coleslaw
Ice Cream
•
Beef Broth, Crackers
Creamed Tuna on
Toast
Steamed Potatoes
Asparagus Salad
Baked Apple</p> | <p>5
Bananas
Poached Eggs
•
Roast Ham, Raisin Sauce
Candied Sweet
Brussels Sprouts
Wilted Spinach
Chocolate Meringue
Pudding
•
Vegetable Soup, Crackers
Meat Balls
Hashed Brown Potatoes
Creamed Carrots
Head Lettuce, French
Dressing
Gingerbread, Hard
Sauce</p> | <p>6
Stewed Peaches
Soft Boiled Eggs
•
Broiled Steaks
Baked Potatoes
Buttered Squash
Tomato, Cottage
Cheese Salad
Cornflake Cream
Dessert
•
Cream of Corn Soup,
Crackers
Lamb Roast
Buttered Rice
Raw Carrot Strips
Fruit Cocktail</p> |
| <p>7
Apple Juice
Scrambled Eggs
•
Broiled Fish, Lemon
Slices
Mashed Potatoes
Buttered English Peas
Congealed Vegetable
Salad
Mahogany Cake
•
Chicken Broth, Crackers
Creamed Chipped Beef
on Toast
Mustard Greens
Tomato Wedges
Butterscotch Pudding</p> | <p>8
Cantaloupe Slices
Bacon, Toast
•
Roast Beef and Gravy
Black-Eyed Peas
Stewed Okra
Stuffed Celery
Banana Pudding
•
Vegetable Soup, Crackers
Brains and Eggs
Steamed Potatoes
Combination Salad
Angel Food Cake</p> | <p>9
Sliced Tomatoes
Broiled Ham
•
Baked Chicken,
Giblet Gravy
Cornbread Dressing
Cauliflower, Hollandaise
Sauce
Stuffed Prune Salad
Strawberry Ice Cream
•
Cream of Pea Soup,
Crackers
Cold Roast Beef
Baked Potatoes
Relish Plate
Fresh Fruit Cup</p> | <p>10
Orange Juice
Poached Eggs
•
Broiled Lamb Chops
Baked Sweet Potatoes
French Style Green Beans
Banana, Toasted Coconut
Salad
Lime Sherbet
•
Cream of Corn Soup,
Crackers
Meat Loaf, Tomato Sauce
Spinach With Hard
Cooked Egg
Raw Carrot, Raisin Salad
Rice Pudding</p> | <p>11
Grapefruit Halves
Scrambled Eggs, Bacon
•
Breaded Veal Cutlets
Creamed Potatoes
Buttered Beets
Lettuce, Thousand
Island Dressing
Frozen Pineapple
Cobbler
•
Beef Broth, Crackers
Broiled Sweetbreads
Buttered Rice
Sliced Tomatoes
Fudge Squares</p> | <p>12
Prune Juice
Soft Boiled Eggs
•
Smothered Chicken
Buttered Potatoes
Buttered Squash
Coleslaw
Ice Cream, Raspberry
Sauce
•
Chicken Broth,
Crackers
Lamb Roast and Gravy
Creole Carrots
Raw Spinach, Cauli-
flower Salad
Fruit Gelatin</p> |
| <p>13
Bananas
Bacon, Toast
•
Mashed Potatoes
Buttered Corn
Asparagus Salad
Broiled Liver
Apricot Whip
•
Tomato Soup, Crackers
Creamed Ham on
Toast
Turnip Greens
Mixed Fruit Salad
Sugar Cookies</p> | <p>14
Applesauce
Poached Eggs
•
Broiled Fish, Tartare
Sauce
Baked Potatoes
Creamed English Peas
Tossed Vegetable Salad
Caramel Pudding
•
Chicken Noodle Soup,
Crackers
Broiled Lamb Chops
Broiled Tomatoes
Apricot, Cottage Cheese
Salad
Baked Custard</p> | <p>15
Tomato Juice
Scrambled Eggs
•
Roast Beef and Gravy
Candied Sweet
Brussels Sprouts
Grated Carrot and
Peanut Salad
Lemon Pudding
•
Vegetable Soup, Crackers
Stuffed Baked Potatoes
With Bacon Strips
Green Beans
Prune Plum Salad
Cup Cakes</p> | <p>16
Cantaloupe Slices
French Toast, Bacon
•
Creamed Chicken in
Timbale Cases
Mashed Potatoes
Creole Carrots
Grapefruit and
Avocado Salad
Ice Cream Topped
With Maraschino Cherries
•
Cream of Pea Soup,
Crackers
Sliced Boiled Ham
Tomato Slices
Potato Salad
Fruit Gelatin</p> | <p>17
Orange Sections
Poached Eggs
•
Swiss Steak
Buttered Rice
Buttered Beets
English Peas and
Cheese Salad
Jelly Roll
•
Tomato Bouillon,
Crackers
Creamed Salmon
on Toast
Turnip Greens
Celery and Green
Pepper Strips
Sliced Peaches</p> | <p>18
Stewed Prunes
Omelet
•
Roast Beef and Gravy
Parsley Potatoes
Lima Beans
Wilted Lettuce
Devil's Food Cake
•
Chicken-Rice Soup,
Crackers
Broiled Lamb Chops
Buttered Corn
Coleslaw
Baked Apple</p> |
| <p>19
V-8 Cocktail
Soft Boiled Eggs
•
Chicken With Rice
Broccoli, Hollandaise
Sauce
Tossed Vegetable Salad
Banana Cake
•
Beef Broth, Crackers
Macaroni and Cheese
Green Beans
Apple and Celery
Salad</p> | <p>20
Grapefruit Halves
Bacon, Toast
•
Baked Ham
Steamed Potatoes
Buttered Asparagus
Congealed Fruit
Salad
Ice Cream
•
Cream of Corn Soup,
Crackers
Meat Balls
Spaghetti and Tomatoes
Stuffed Celery
Stewed Apricots</p> | <p>21
Apple Juice
Poached Eggs
•
Broiled Fish With
Catchup
Creamed Potatoes
English Peas
Beet Salad
Prune Whip
•
Cream of Potato Soup,
Crackers
Broiled Liver
Buttered Spinach
Tomato and Cottage
Cheese Salad
Oatmeal Cookies</p> | <p>22
Bananas
Soft Boiled Eggs
•
Roast Lamb and Gravy
Black-Eyed Peas
Buttered Squash
Cabbage and Raisin
Salad
Fresh Fruit Cup
•
Chicken Broth, Crackers
Broiled Sweetbreads
Baked Potatoes
Raw Carrot Strips
Tapioca Pudding</p> | <p>23
Prune Juice
Bacon, Toast
•
Roast Chicken,
Giblet Gravy
Cornbread Dressing
Asparagus, Hollandaise
Sauce
Relish Plate
Chocolate Ice Cream
•
Cream of Pea Soup,
Crackers
Creamed Chipped Beef
on Toast
Buttered Potatoes
Head Lettuce, French
Dressing
Graham Cracker Date
Pudding</p> | <p>24
Stewed Apples
Poached Eggs
•
Broiled Steaks
Mashed Potatoes
Green Beans
Tomato Wedges
Green Pepper Strips
Banana Pudding
•
Beef Broth, Crackers
Lamb Chops
Potato Loaf
Buttered Beets
Angel Food Cake</p> |
| <p>25
Grapefruit Juice
Bacon, Toast
•
Chicken à la King
on Toast
Baked Potatoes
Buttered Asparagus
Congealed Vegetable Salad
Apricot Upside-Down Cake
•
Cream of Tomato Soup,
Crackers
Meat Pin Wheels
Creole Carrots
Deviled Egg Salad
Raisin-Rice Pudding</p> | <p>26
Orange Halves
Creamed Eggs on Toast
•
Roast Squab, Celery
Dressing
Baked Squash
Broccoli
Prune Plum Salad,
Grated Cheese
Mincemeat Squares
•
Roast Lamb, Currant
Jelly
Mashed Yams
Spinach
Lettuce, Thousand
Island Dressing
Caramel Pudding</p> | <p>27
Honey Dew Melon
Frittled Beef
•
Roast Beef and Gravy
Hashed Brown
Potatoes
Lima Beans
Stuffed Tomato Salad
Pound Cake
•
Bean Soup, Crackers
Cheese Soufflé
Baked Grits
Buttered Asparagus
Fruit Cup</p> | <p>28
Grapefruit
Omelet
•
Baked Fish, Bread
Crumb Dressing
Parsley Potatoes
Green Peas
Pear Salad
Lemon Meringue Pie
•
Cream of Celery Soup,
Crackers
Bacon and Tomato
Sandwiches
Sliced Cheese
Deviled Egg Salad
Fresh Peaches</p> | <p>29
Stewed Peaches
Soft Boiled Eggs
•
Broiled Ham
Buttered Rice
Fresh Greens
Combination Salad
Apple Tapioca
•
Chicken Salad
Hard Cooked Egg Slices
Raw Carrot Strips
Pickled Beets
Olives
Floating Island</p> | <p>30
Tomato Juice
Link Sausages
•
Broiled Steak and
Gravy
Mashed Potatoes
Carrot Rings and Peas
Under-the-Sea Salad
Icebox Cake à la Mode
•
Vegetable Soup, Crackers
Brains and Eggs
Baked Potatoes
Green Beans
Wilted Lettuce
Canned Apricots</p> |

Ready-to-eat or cooked cereals are offered on all breakfast menus.

C. Chang
Memorial Hospital
San Angelo, Tex.

6
Stewed Peaches
Boiled Eggs

•
Stewed Steaks
Stewed Potatoes
Stewed Squash
Stewed Potato, Cottage
Stewed Cheese Salad
Stewed Flake Cream
Dessert

•
Corn Soup,
Crackers
Roast
Stewed Rice
Carrot Strips
Cocktail

12
Stewed Juice
Boiled Eggs

•
Stewed Chicken
Stewed Potatoes
Stewed Squash
Stewed Cabbage
Stewed Raspberry
Sauce

•
Stewed Broth,
Crackers
Stewed Meat and Gravy
Stewed Carrots
Stewed Cauliflower
Stewed Salad
Gelatin

18
Stewed Prunes
Stewed Meat

•
Stewed Beef and Gravy
Stewed Potatoes
Stewed Beans
Stewed Lettuce
Stewed Food Cake

•
Stewed Rice Soup,
Stewed Crackers
Stewed Lamb Chops
Stewed Corn
Stewed Cabbage
Stewed Apple

4
Stewed Apples
Stewed Eggs

•
Stewed Steaks
Stewed Potatoes
Stewed Beans
Stewed Weenies
Stewed Pepper Strips
Stewed Pudding

•
Stewed Crackers
Stewed Chops
Stewed Loaf
Stewed Beets
Stewed Food Cake

•
Stewed Juice
Stewed Usages

•
Stewed Steak and
Stewed Potatoes
Stewed and Peas
Stewed Sea Salad
Stewed à la Mode

•
Stewed Crackers
Stewed Eggs
Stewed Potatoes
Stewed Beans
Stewed Lettuce
Stewed Carrots

HOSPITAL



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A Little Prevention Means Less "Fixing"

AL MAJEWSKI

Assistant Engineer, Wesley Memorial Hospital, Chicago

WE HAD an interesting phone call just before I came up here. "Engineering"—it was a lady's voice, talking fast and urgently. Might even have been a nurse. That's the point, we never did find out who it was. "Hello, hello, Engineering, send someone up immediately. The window in Mr. A's room won't open." Click of the telephone. She hung up. That doesn't happen often, but it has happened before.

Certain things bother the engineering department—actions or requests so foolish that if someone had used his head, the action might not have been performed or the request made. The incident cited is an example.

We don't know who called. Maybe the person went back to have another look at the window. Perhaps she even looked at the lock. We don't mind being called when we're needed; that's part of our job. In fact, we are at present answering calls on more than 75 jobs a day. Some may take only three or four minutes, others may take two men some two or three hours, many could have been avoided.

The Nurses Must Help

This is a highly centralized hospital, new and equipped with intricate modern equipment that must be kept in smooth working order at all times. *That's our job, but it's yours, too.* This is the fourth year of operation, and almost immediately after the building was completed it became impossible to obtain most of the equipment and material we had been fortunate in obtaining for Wesley. Major replacements are next to impossible.

Let's look at the elevators for a moment. We have five passenger cars, three of which have been designated as freight cars although there

is no difference in construction. Two of them travel at 500 feet a minute; two at 600 feet a minute, and one at 700 feet a minute. Everything in the building, including the elevators, is overworked, since the normal capacity of the hospital—545 beds—has been expanded to meet war-time requirements and now houses between 700 and 800 patients daily; one day last week we were up to 900, including new-born.

The elevators are an important part of the building; they are your means of transportation. The operators, like anyone new on the job, need aid in learning to operate the elevators. But after he has learned how to operate them, the operator should have the sole responsibility of the car; the passengers should remain such. Call out the number of the floor you desire before the door of the elevator closes.

The cars are run automatically and it is the duty of the operator to push the buttons for all floors desired and from then on the elevators run themselves. If you neglect to call

As part of the orientation course for new student nurses at Wesley Memorial Hospital, Chicago, the assistant engineer in charge of mechanical maintenance gives an informal talk to incoming groups, in which he outlines "do's and don'ts" of maintenance. Here is a stenographic record of his latest discussion

your floor until after the car is in motion, don't be surprised if the car doesn't stop. The operator should be allowed the privilege of pressing the floor buttons, and confusion and loss of time can be avoided if that privilege is recognized and passengers keep their hands off the controls.

Two Chances to Think

Another problem along this line is the dumb-waiter. After putting something on the dumb-waiter, press the button for the floor for which the article is intended. This "elevator" won't stop until it reaches the specific floor that is its destination. There are two sets of doors and the elevator won't start until both inner and outer doors are closed. These doors offer a double chance for you to think—to determine if the correct articles have been placed in the "elevator" and if the correct button or buttons have been pushed.

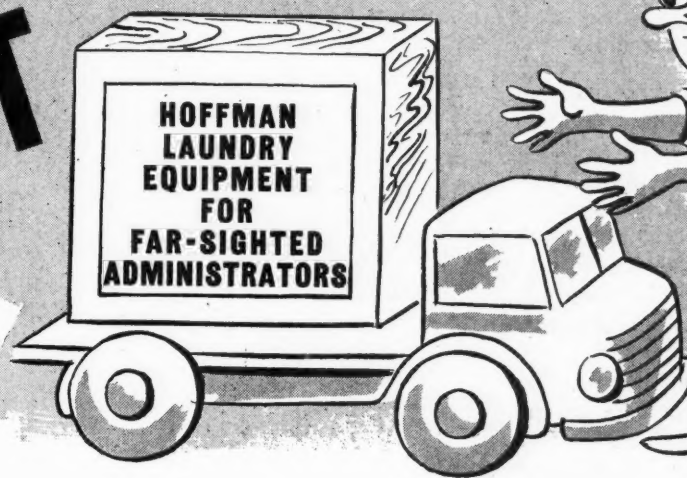
Suppose you should have three patients, one on the third floor who wants hot coffee, one on the sixth



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floor who wants iced orange juice and one on the tenth floor who wants warm milk. These foods are placed on the dumb-waiter. Upon arriving at the first stop, the third floor, the coffee is removed, but through forgetfulness or neglect only the outer doors to the waiter are closed. Thus, the elevator remains at the third floor.

After the dietary department indicates that the food has been sent, the maintenance department receives calls from the sixth and tenth floors, one wondering what happened to the orange juice, the other inquiring about the warm milk. An engineer calls the third floor and asks if the elevator is still there. Without going over to look at the elevator, which is about 50 feet from the nurse's station, the nurse says it is not there.

Then the Hunt Begins

A search must then be made on each floor to determine where the elevator has been detained—a loss of time and effort that might have been avoided had care been exercised in determining that both inner and outer doors on the third floor were closed. And also, by that time, the orange juice is warm and the milk, cold.

There are two tray bearers. The large belt in the kitchen moves constantly toward the tray bearers while servers put the food on the individual trays as they go past on the belt. At the end of the large belt, when the trays have been completely made up, a lift carries the trays to the floors. There is an opening to this lift on every floor. If at any time you find yourself with rubbish of some sort in your hand, please don't throw it down this convenient opening to the lift. There are plenty of appropriate places for disposing of rubbish.

Hoppers, bedpan washers and sinks give the maintenance department a lot of trouble. Sinks have a drain filter to catch any foreign matter that might otherwise go down the drain. The drain filters are removable. Pull out the filter and the refuse will go down the drain pipe. This can and often does cause a mess in the lower floor sinks because sooner or later that refuse will accumulate and clog the pipe, preventing passage of water, which consequently overflows in the sinks on the lower floors.

Instead of removing the drain filter, remove the substances caught in it or, better yet, don't put things in the sink that you know shouldn't or won't go down the drain. A little thought for the other person will save a lot of trouble.

The same is true of bedpan washers and hoppers. Every hopper enters into the "stack," a disposal shaft running through the building to the basement. At one time, someone threw a bandage down the stack and it lodged somewhere near the basement, which caused an overflow in hoppers on the second and third floors. The result: two or three men were required to clear the stack line, while seven or eight more mopped the floor.

This incident happened at night and the next day all the floors had to be washed, waxed and buffed. Had it happened during the day it would have caused even more trouble, with visitors and doctors walking the floors.

Everywhere you go you will find a lot of buttons. If you go into a room and press a button or turn a switch that you hope is the light switch and the light doesn't turn on, you either have the wrong button or the light bulb needs replacing.

Assuming you have pressed the wrong button, before pressing another be sure the first button is returned to its former position. All the buttons have a purpose and you might have halted some operation when you pressed the first button, and unless the error is corrected complications may result.

Switches Have Fascination

Some people just have a mania for pressing buttons. In the main lobby there is a panel with two red lights and two switches which are not to be used except by the fire department. They are emergency switches that are needed in a building of this size. These switches for the emergency lighting system must be replaced from three to five times a week because someone has, out of curiosity, tripped a switch. When we receive numberless calls about lights being out all over the building, we know that these switches have been tampered with.

Oxygen setups are handled by the maintenance department. One day a call came at 12:15 p.m. for a refill, while the engineers were eating their

lunch. Oxygen calls always have priority, so an engineer ceased eating, prepared the equipment and went up on the elevator. In the meantime another phone call demanded immediate attention to that request for oxygen—it had completely run out and the patient needed it at once. When the engineer arrived in the room with the fresh setup, he found that the old tank was still full. Someone had simply neglected to open the valve.

An unnecessary request, such as that, which could have been avoided by proper examination of equipment and checking valves not only wastes time and energy but also involves questioning by the office that compiles statistics on oxygen setups. The office wants to know why a certain order for oxygen has been marked off the record.

Wall outlets for electric current lock immediately after the plug has been inserted. By turning the plug a quarter of a turn to the left, it can be removed with no difficulty, but anyone unfamiliar with this type of plug may pull or jerk at it until the cord pulls loose, necessitating a new plug and repair to the cord. Usually a fuse is also blown.

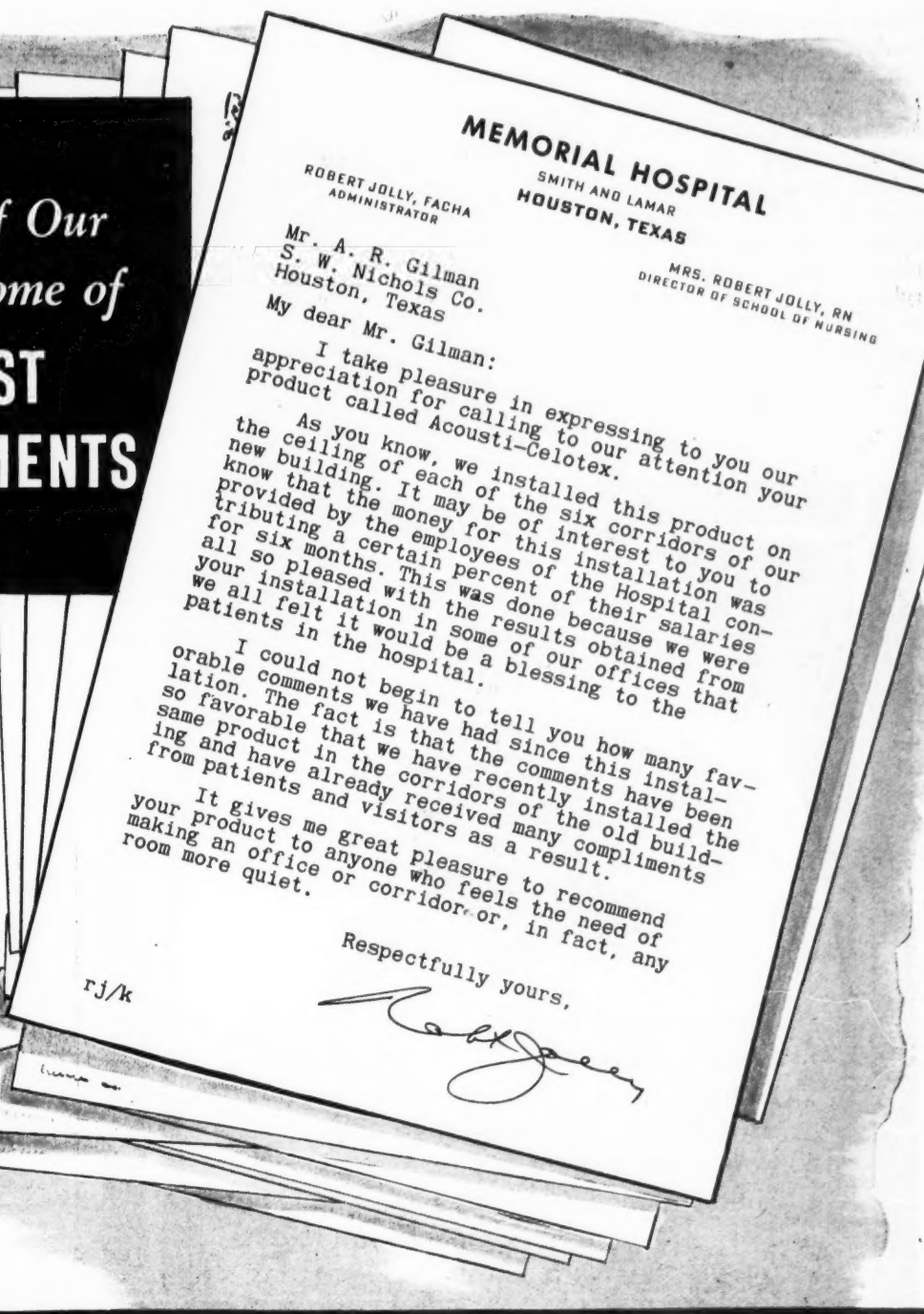
Plugs Can't Be Replaced

The greatest difficulty is that plugs of this type are almost impossible to obtain, the same being true of the wire. Thus, from an extremely limited supply, we must order plugs for replacement purposes. The patients must have their lamps. By remembering to turn the plug one quarter of a turn to the left, needless waste of material and labor can be avoided.

We have a radio system that cost about \$10,000. It could have been installed in a much more foolproof way, but that would have raised the original cost. The radios themselves are down in the basement; speakers are in patient rooms. If at any time the plug for the speaker is not firmly placed in the socket, reception all through the building is faulty.

If we receive 30 or 40 calls about the same time that the radio reception is poor, we know that someone has been careless about plugging in the speaker. We must cut off each wing of each floor to find out where the trouble is originating. After the wing has been determined, a search must be made of each room in that wing before the origin of the inter-

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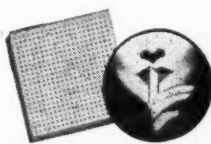
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ference is discovered. If the plug is broken, even if the patient would like to listen to the radio, take it out, for using it in that condition will also spoil reception everywhere else in the building.

Our signal cords and plugs are made by one of the best manufacturers in the country. However, the plug is made of plastic. Usually a rubber ring around it will prevent breakage, but these rings are not obtainable today. Many of these plugs are broken. Either they are not pinned to the sheets or the cord falls

to the floor. Some of them get caught, and smashed, between the bed and the wall.

The cords are a seven wire cable and it is a lot of work to put in another plug, but *you can't get plugs*. We have an order in now for them, just an order on file. It may be months and months before they are available. Take care of the plugs. Pin them to the bed or loop them over the bedpost. After the war we will be able to get rubber that will prevent breakage, but until then we must just be careful.

Another problem is locks. If your key won't unlock a door, don't force the key to turn until you break it in the lock. If the key is broken in the lock it means the lock must be drilled out, and these locks cannot be replaced. The material just cannot be obtained.

Padlocks cost \$1 apiece. These padlocks are given to the individual with one key; another key is kept downstairs. If one key is lost, there is still a key available and a duplicate is made from this extra. If someone forgets his key, and the man in charge of the keys has gone home, the person breaks the lock, but where are you going to get another lock these days?

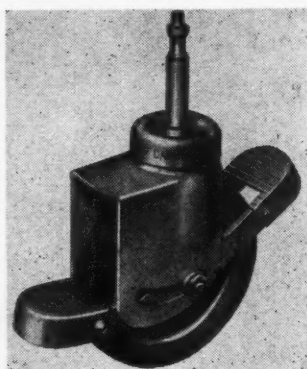
Although there are several pass keys in the building, it is not good policy to lend them to every person who says he has misplaced his key. How do we know that person who asks to have a locker opened really wants his own locker opened? Suppose we lend him the pass key; perhaps he is just looking for a chance to steal from another locker. *Always remember to carry your locker key with you!*

Tube System Is Complex

We have a pneumatic tube system similar to those in department stores, except that our system doesn't handle money; it handles requisitions, material from central supply, special items for the kitchen. This is an extremely intricate unit—put something down an opening and just wait until it comes back. This system gets plugged up once in a while. Medicine bottles are sometimes put into the tube without first being placed in a cylinder. If the tube line gets plugged, the engineers must follow the line, working in a space 3 feet high at the highest points and 1 foot high at the lowest.

Once someone sent down a surgery cap without the aid of a cylinder that plugged the line; and another time an egg was sent down. The egg came down whole until it arrived in the tube room.

Try to figure out all angles to a problem. Think twice, at least twice, before acting. Don't make unnecessary work for the other fellow. A little thought, a little careful attention to detail may solve a problem before it becomes a problem. Let's have a little more prevention and less fixing.



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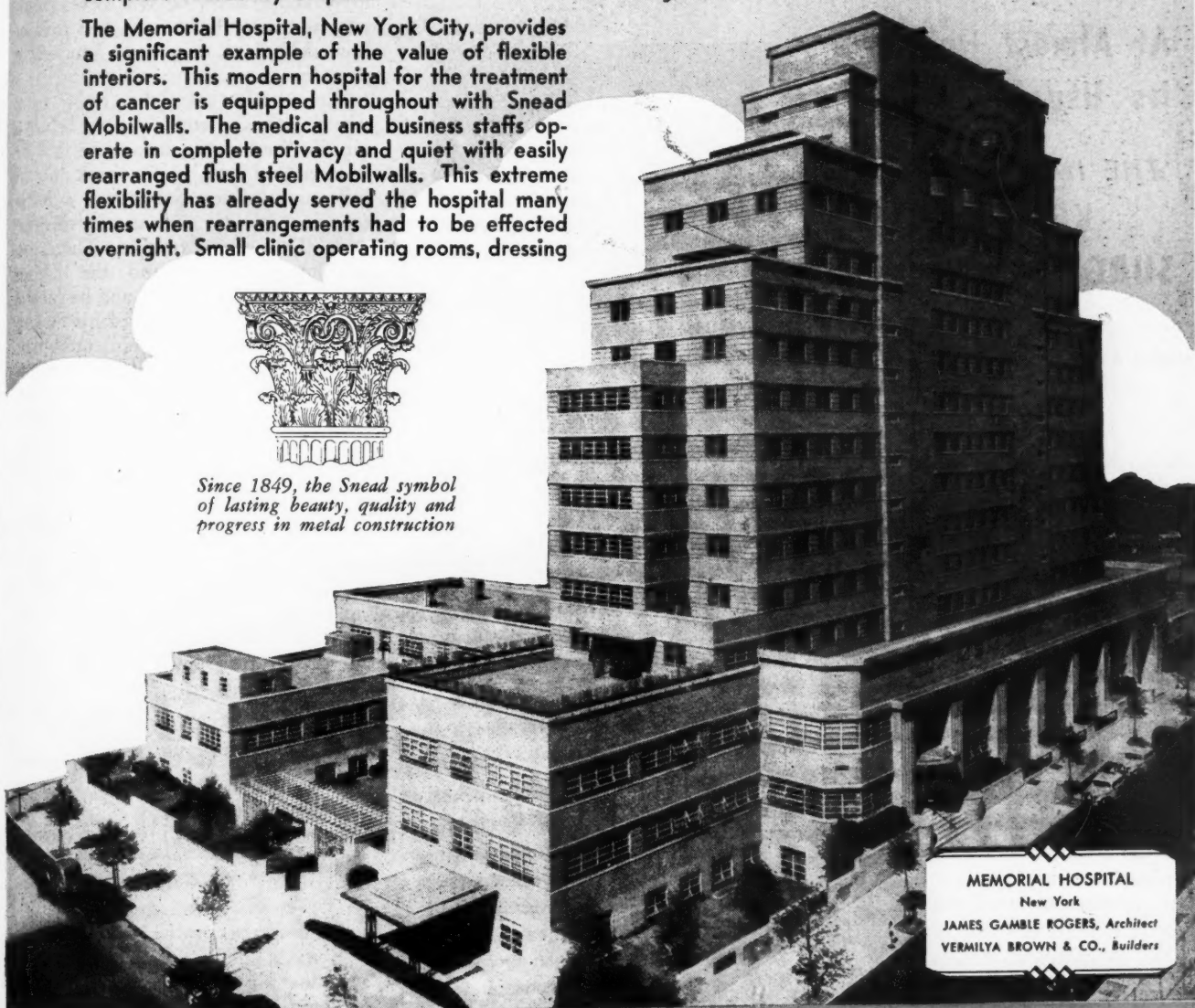
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Beware of Ladders

During a conversation the other day with a maintenance man who speaks with authority, the question of hazards came up. "Ladders cause more trouble in most institutions than anything else," he declared. "In the first place, too often an employe is told to work from a ladder when he is not used to it and, second, the ladder hasn't been

checked carefully to see whether it should be repaired or thrown away. I suspect that a great many of them now in use should be discarded.

"The average porter isn't a ladder man," our friend continued. "This means that he must be instructed how to wash from a ladder and how to work from it. He must be shown the position for placing the ladder."

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Suggestions on Personnel

From the subject of hazards, the conversation switched to the selection of janitors and personnel problems. "Of course, in these days you have to take what you can get," our maintenance friend continued, "but to tell you the truth I was never one to take much stock in references. I have always figured that you have to size a man up for yourself. For example, you can't tell whether your man is a painter by just talking to him. You've got to see him with a paint brush in his hands. This means that if you are the one who is employing him, you must know how the work should be done.

"What I try to discover in my first interview with an applicant is whether or not he is honest, loyal and will give service. If he isn't loyal and isn't going to be cooperative, he will never work out, no matter how much he's paid or how skillful he may be in handling a paint brush or other equipment.

"Once you have the right man, which comes pretty close to being a miracle these days, make sure that he is interfered with in his work just as little as possible. Sometimes a nurse or office employe will start giving orders. This means trouble. There can be but one head and the janitor should take orders from, and be subject to, no one but the head of his department. Another point to remember is to adopt work schedules and stick to them.

"Personally, I never was one for getting too many men of one race or religion in a group. Before you know it, cliques get started and nothing will ruin morale quicker than cliques.

"We all like to be considered and to have a voice in things. When the individual has an idea or makes a suggestion, act upon it and develop it. You can't treat people as if they were automatons. I am careful never to take advantage of an employe. Supervision is all right; it is important, in fact, but it can and should be done without creating antagonism.

"And there should be encouragement always. If you have good material to start with, there is no reason why the plumber's helper cannot one day become the plumber and the wall-washer, the painter. There is no telling how far a person can go if he has a natural aptitude for his work.

"Finally, supply your employes with good looking uniforms, with some sort of identification on the arm. What if they do cost a bit more than overalls? The uniform will repay you many times over. Just try it and see. You will find an employe showing new pride in his work, pride in himself and pride in the institution that employs him. It's the best investment any maintenance head can make."

WEDNESDAY

"We need dependability"

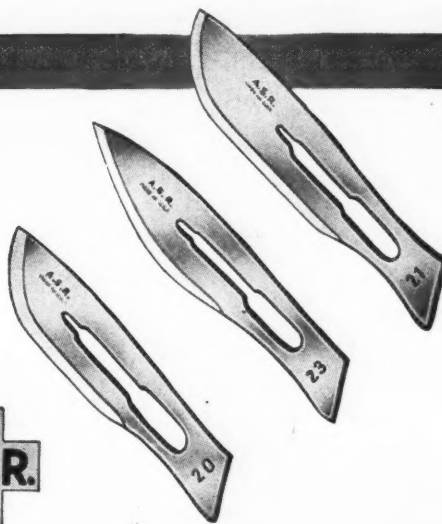
(taken from a doctor's diary)



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NEWS IN REVIEW

Columbia Hospital Administration Course Aided by Kellogg Foundation Grant

The first of what are expected to be several courses in hospital administration to be aided by the Kellogg Foundation will start at Columbia University beginning September 27. The course will be of twenty-one months' duration: an academic year in residence at Columbia University and a calendar year of supervised assistantship in an affiliated hospital. A bachelor's degree will be the minimum requirement for admission. Women will be accepted on the same terms as men. The course will be offered through the School of Public Health of the Faculty of Medicine.

Dr. Claude W. Munger, administrator of Saint Luke's Hospital, New York City, is to serve as professor of hospital administration. Doctor Munger is a past president of the American Hospital Association and president of the American College of Hospital Administrators. Dr. Willard C. Rappleye, dean of the Faculty of Medicine, has long been interested in training for hospital administration and in 1922 wrote one of the earliest studies of this problem entitled "Principles of Hospital Administration

and the Training of Hospital Executives." This study was financed by the Rockefeller Foundation.

The university is offering a winter and spring course in hospital management that will cover medical terminology and medical records and the standards of quality for institutional supplies and medical and surgical supplies. Instruction will be given by Dewey H. Palmer, research director of the Hospital Bureau of Standards and Supplies, Inc.; Eleanor Lee, assistant professor of nursing at Columbia University, and Dorothy L. Kurtz, supervisor of the records department of Presbyterian Hospital in New York City.

MacLean Serves Navy as Civilian Consultant

Dr. Basil C. MacLean, director of Strong Memorial Hospital, Rochester, N. Y., has been appointed a civilian consultant by Secretary of the Navy Forrestal to survey naval hospitals and the problems of the Bureau of Medicine

and Surgery in the Navy. A plane has been put at Doctor MacLean's disposal to expedite this extra work.

Recently, he was appointed professor of hospital administration of the University of Rochester. He is chairman of Governor Dewey's commission to survey medical needs of New York State. He served for a period as a lieutenant colonel in the office of the surgeon general of the U. S. Army. He is a past president of the A.H.A. and the A.C.H.A. and is active as a hospital consultant.

Veterans' Hospitals Given Higher Priority Rating

WASHINGTON, D. C.—The Veterans Administration was placed on an equal basis with the military in the matter of preference ratings by W.P.B. Directive 39 issued on July 16. Under former orders, the Veterans Administration had an AA-3 rating on its hospital construction program with the privilege of up-rating 7½ per cent of this to AA-1 in the case of bottleneck items. It also had an AA-1 on maintenance, repair and operating supplies.

Under the new program the Veterans Administration can assign preference ratings, including the MM (military) rating, to all of its procurement.

This program gives the Veterans Administration a much wider advantage over civilian hospitals than it heretofore enjoyed. The hospital section of W.P.B. has endeavored to see that civilian hospitals have the same priorities as veterans' hospitals but with the tremendous problem facing the latter when several million veterans return this policy may no longer be practical.

Cadet Nurse Quota Topped for Second Time

WASHINGTON, D. C.—For the second consecutive year the U. S. Cadet Nurse Corps has exceeded its recruitment quota, according to a statement of Dr. Thomas Parran June 30. During the last twelve months 61,471 new student nurses have enrolled in schools of nursing.

The quota for the fiscal year ending June 30 was 60,000. Military and civilian nursing needs will be reviewed by the U. S. Public Health Service late in 1945 to determine whether any change in the student nurse quota is indicated in relation to the course of the war.

Doctor Parran praised the many thousands of nurses and hospital administrators who have worked as volunteer recruiters in local and state affiliates of the National Nursing Council for War Service and the American Hospital Association.

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Half Year Totals for Blue Cross Plans Set New Record

With an increase of 1,140,623 subscribers in the second quarter and 2,282,000 in the first half of 1945, the total enrollment of the 85 Blue Cross plans of the United States and Canada reached 18,794,000 on July 1. These gains were the largest ever recorded in any half year period or second quarter period. The first quarter of this year slightly exceeded the second quarter.

The plans which gained more than 50,000 additional members for the first half year of 1945 together with their net increases are: New York City, 303,000; Boston, 244,000; Indianapolis, 123,000; Newark, 103,000; Toronto, Ont., 98,000; Milwaukee, 89,000; St. Louis, 89,000; Philadelphia, 75,000; New Haven, Conn., 64,000; Chicago and Detroit, 56,000 each, and Topeka, Kan., 52,000.

During the second quarter the following plans gained 20,000 or more subscribers: Boston, 149,000; New York City, 117,000; Detroit, 59,000; Toronto, Ont., 58,000; St. Louis, 53,000; New Haven, Conn., 47,000; Newark, N. J., 43,000; Milwaukee, 42,000; Pittsburgh, 39,000; Philadelphia, 35,000; Topeka, Kan., 29,000; Des Moines, Iowa, 23,000, and Denver, 22,000.

Petry Clarifies Status of Graduate Nurses Under P. and A. S.

WASHINGTON, D. C.—Lucile Petry, director, Division of Nurse Education, U.S.P.H.S., in a memorandum dated July 9 called the attention of nurse directors of postgraduate programs to a change that will make it possible for Procurement and Assignment to classify a greater number of nurses as essential for study. This service has instructed state and local chairmen for nurses to return to an earlier directive relative to the classification of graduate nurses who are enrolling for postgraduate programs.

The directive, dated July 15, 1944, recommends that nurses preparing for essential nursing educational or public health positions be classified as essential, if they are potentially qualified for this work and can be prepared in the shortest possible length of time.

All graduate nurses enrolling for the fall term and after should be classified as essential for postgraduate study, Miss Petry recommended. "Potential qualifications" may be determined, she said, through the nurse's recent employer, the director of school from which graduated or the director of the postgraduate program.

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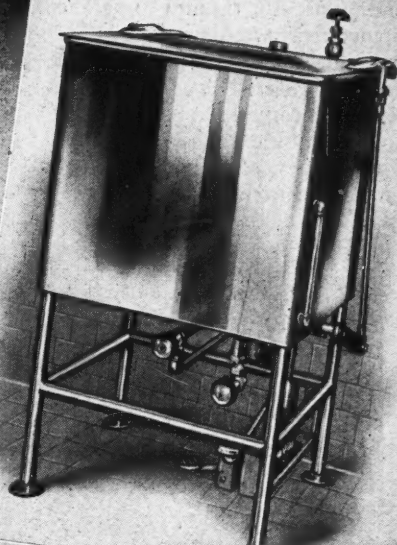
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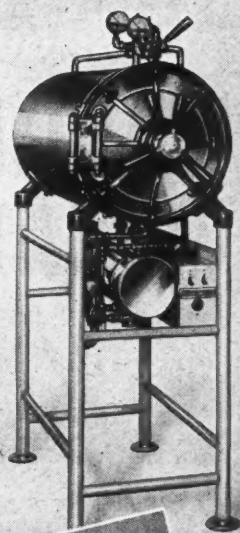
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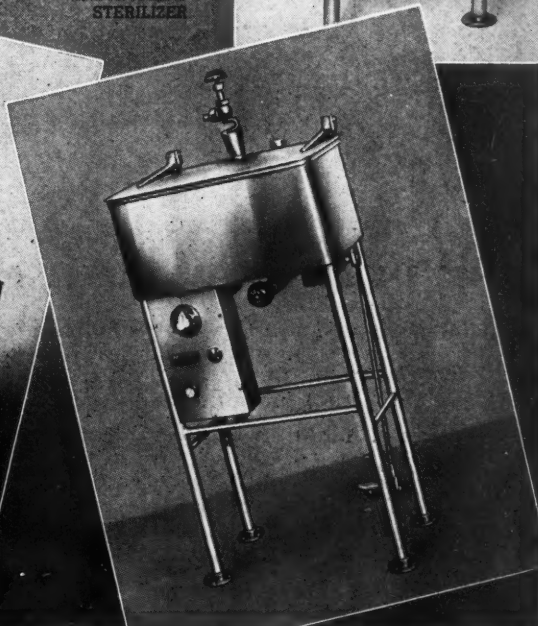
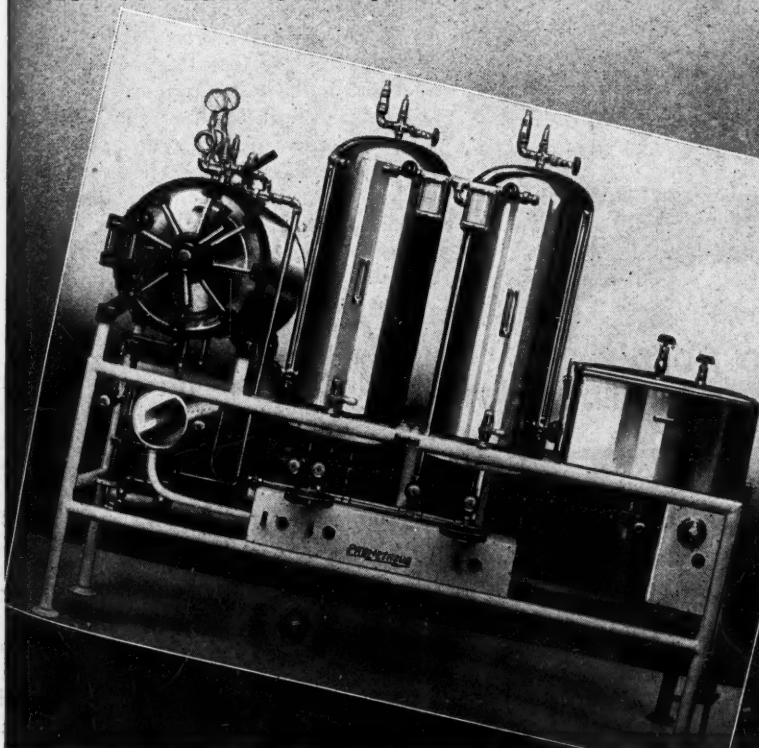
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A.H.A. Personnel Institute Covers Union Problems, Employee Practices

By NELLIE GORGAS

The program of the advanced institute on personnel management held at Yale University June 25 to 30 was divided into three parts: (1) training programs, (2) employee representation and (3) specific personnel practices in hospitals. Each part was covered first by a presentation of the theory and philosophy behind it; second, by a discussion of applications in industry, and, finally, by demonstrating adaptations in our field.

In spite of travel discomforts and a sizzling heat wave, the 55 students from 22 states and South America agreed that they had been amply repaid.

After each paper a selected panel asked questions intended to point up the theory and discussion to specific hospital problems. Occasionally, the subjects were opened for general discussion.

Some of the philosophy presented was that a training program could be initi-

ated relatively easily if supervisors are inculcated with the idea that the better they develop those who work for them, the easier their own job will be; that a well-worked-out suggestion box system will save any organization thousands of dollars in constructive criticisms and schemes if proper incentives and recognition are given; that public education systems will cooperate with adult training programs if approached earnestly and intelligently by hospitals. An excellent demonstration of the induction program for new hospital workers was presented by Doris P. McLeod, training coordinator, New Haven Hospital, New Haven, Conn., which showed a neat and suggestive application of some of the theory presented.

Mark A. May, director of the Institute of Human Relations, Yale University, R. Carter Nymman, Yale personnel director, Herman Feldman, professor of industrial relations, Tuck School, Dartmouth College, and Whiting Williams, counsel in employee relations, Cleveland, discussed some of the fundamental factors that make people react as they do to various situations, why they work at all and why they work well together sometimes and poorly at others. A practical discussion by James Hamilton on how to sell the board of trustees on a personnel department showed how one can build on these factors.

The concept of "pooled judgment" was introduced—a system of getting a group of interested persons thinking a problem through simultaneously and reaching a conclusion together, rather than each coming to a decision individually and then trying to reconcile their individual judgments.

John McConnell, associate professor of New York University and a member of the Regional War Labor Board involved in the recent union issue in the New York hospitals, gave a clear and concise presentation of the history and development of the legal aspects of employee representation. The present thinking, he feels, seems to be that just because employees work for a charitable institution is no reason they are not entitled to the same protection from the government as are other employees who feel they can gain their rights only through collective action.

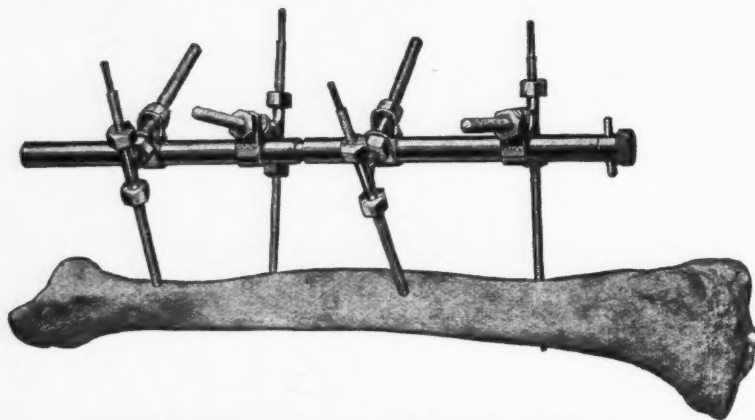
Excellent contrasting papers as to the success of their respective concerns in handling their personnel problems were presented by Rodney Chase, Chase Brass and Copper Company, Waterbury, Conn., whose organization is completely unionized, and by Thomas I. S. Boak, Winchester Repeating Arms Company, New Haven, Conn., in whose firm there is no union organization.

Whiting Williams, it was generally agreed, presented the highlight of the institute when, on the basis of his actual experience as a worker in a coal mine,

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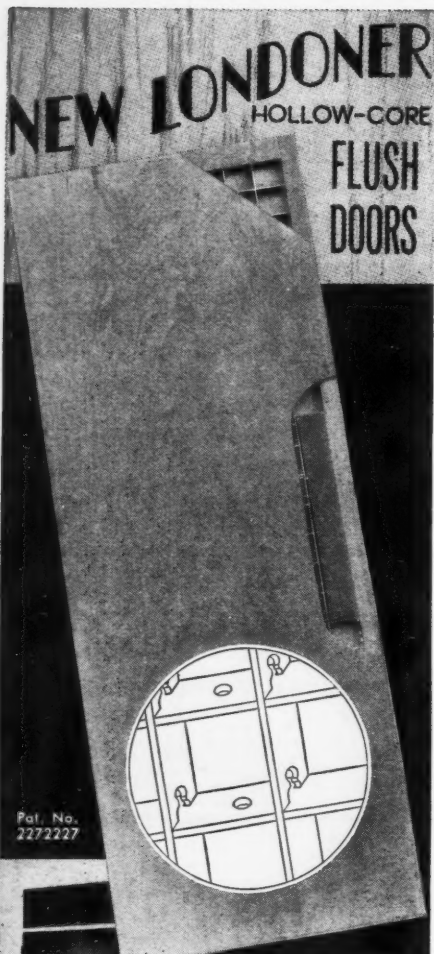
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he expanded on his philosophy that there are two fundamental factors which impel men to work, *i.e.* fear and hope—fear of loss of money or prestige and hope of promotion or recognition.

Practical information was given by Carter Nyman as to the details of negotiating a union contract. Two lively discussion periods, led by James Hamilton, with Dr. Donald C. Smelzer active on the panel, completed the institute. In these discussions the members of the personnel committee summarized current practices and thinking with regard to various forms of employer-employee relationships and other working conditions.

The Connecticut Hospital Association "mixer," the "Hospital Follies," which demonstrated the use of drama for teaching, and the final banquet and social gathering relieved the tension and added spice to the program.

A.H.A. Membership Drive Nets 554 Applications

By KENNETH WILLIAMSON

Concluding its first extensive drive for new institutional members since the expanded program became effective, the American Hospital Association has mailed the final letter in the 90 day program, which began April 1. Five hundred replies were received in six days to this last letter which was sent to the hospitals that had not replied to previous communications. In it President Smelzer asked the reason "why we failed to interest you in membership."

Introduced as an innovation, the dual approach to the administrators of the prospective member hospitals and the presidents of the boards of trustees, each with a particular appeal, has proved to be highly effective and, it is believed, has assisted administrators considerably in "selling" their boards. The highlight of this trustee approach was a personal letter from Charles Kettering, member of the board of Miami Valley Hospital of Dayton, and vice president of General Motors Corporation, to hospital board presidents.

Personal letters from the presidents of each state association, from A.H.A. delegates and from presidents of many of the Blue Cross plans, together with three prepared mailing pieces which tell the story of the American Hospital Association and its work, were mailed at two week intervals. As of July 18, 554 applications had been received and out of this number 110 new memberships had been completed. Many others are in the process of completion.

State associations, affiliated and non-affiliated alike, have cooperated through personal follow-up by state officers and committee members. Membership has been obtained for all state mental disease hospitals in Illinois and Virginia.

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Radiologic Dispute Breaks Out Again in Connecticut Hospitals

The radiologic fight broke out again last month—this time in Connecticut. In answer to a request from the Connecticut Medical Society for a change in the status of radiology practice in hospitals, the Connecticut Hospital Association has prepared a thorough-going statement on the whole problem.

The hospital answer repeats the principles of relationship between hospitals and radiologists as worked out by the A.H.A. and the various specialty groups

in 1939 and reaffirmed by the A.M.A. and the A.H.A. in 1944.

The radiologists want to break the charge for radiology into two parts—as was tried in Cleveland some years ago—to eliminate their services from Blue Cross contracts. The hospitals answered this by pointing out that radiologists accept charges by hospitals for x-ray services to insurance companies under the compensation law while objecting to such charges under Blue Cross plans.

While acknowledging that radiology is a part of the practice of medicine, the hospitals point out that the radiologist cannot always be given exactly the same status as other chiefs of services because

he usually has a monopoly of the practice in his department and engages technicians and supervises their work.

The hospitals could see no advantage to be derived from separating the professional service fee from the technical service fee. That radiologic charges embrace professional services is "fairly well known."

The radiologists stated that hospitals should make a charge for technical radiological service based upon actual expenses plus a reasonable return on invested capital and for overhead and replacement but that the radiological department should not be looked upon as a source of extraordinary profit to the hospital.

To this the hospitals replied that the radiologists were ignoring two fundamental points, namely, that the practice of radiology in hospitals is of forty years' duration during which time the hospitals made the capital investment and took the risks and, second, that the concentration of x-ray services at hospitals is the result of community cooperation. If radiologists have been exploited that is a local situation to be corrected locally.

The hospitals urged the radiologists to agree to reduction of x-ray charges and pointed out that the radiologists usually try to prevent this. If x-ray charges are reduced, other hospital charges may have to be increased, since the hospital is a unit.

The hospitals agree that the control of professional radiological fees should be under the jurisdiction of the radiologists, provided that by professional fees is meant the payment to the radiologists. They point out that no radiologist has to work for any particular arrangement and is entirely free to place his own valuation on his services.

The hospitals point out that book-keeping mechanics have little to do with the practice of medicine and so a change in the manner of rendering bills would not "preserve the private practice of radiology in the hospital" as claimed by the radiologists.

The hospitals ask the radiologists to present specific evidence of the exploitation which they claim has taken place so that it can be prevented. They also believe that further evidence should be presented to show that the proposed changes would reduce the cost of x-ray examinations. They fear the change will have the opposite effect.



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Start Construction of Wing

Construction on a 66 bed addition to St. Joseph's Community Hospital at West Bend, Wis., will begin within a month and is expected to be completed by next March. The new wing will more than double the hospital's present 32 bed capacity.

131

Budget Director Urges Postponement of D. C. Medical Center Bill

By EVA ADAMS CROSS

WASHINGTON, D. C.—Harold D. Smith, Director of the Budget, in a statement to the House district committee June 25 pointed out certain deficiencies in the Senate-approved S. 223, a bill to provide for a hospital center for the District of Columbia. He advised postponement of further action until completion about October 1 of the survey of hospital needs of metropolitan Washington initiated

under the auspices of the Metropolitan Health Council. It is suggested that this proposed medical center should be evaluated in the light of whatever over-all plan for providing hospital care to the community is evolved from that survey, he said.

Sen. Millard Tydings, co-author of the bill, has protested that such critics of the present bill have failed to come forward with a better proposal. The Tydings-Bilbo plan proposes that the government provide two thirds of the cost of the buildings only, which thereafter are to be maintained and operated without any further expense to the government.

The participating hospitals put up one third of the money and all of their endowments behind the proposition to maintain the center.

Mr. Smith's memorandum outlined the following deficiencies in the bill as follows:

Organization. The bill provides a complicated plan of organization which will be extremely difficult of operation. Under the bill, three or more separate managements would attempt to operate separate hospitals under the same roof, using certain facilities in common. Corporate, managerial and financial integration of these hospitals is not contemplated.

Financial Arrangement. 1. No limitation is placed on the amount authorized to be appropriated.

2. No part of the cost is to be borne by the District of Columbia government.

3. The proposed method of financing is novel. It does not conform to the pattern of matching federal funds generally followed in grant-in-aid programs.

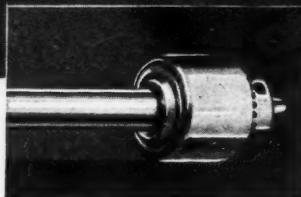
4. The obligation of the participating hospitals to reimburse the government for one third of the cost of the hospital would not be secured by a lien on the assets of the hospital or on their revenues and, therefore, any securities given by the hospitals would be of doubtful salable value.

5. Section 5 (a) of the bill would appear objectionable in providing for outright grants of federal funds by a private corporation to other private corporations, i.e. "affiliating hospitals."

Construction. Although the federal government is putting up all the money and is responsible for construction of the center, it does not have control of the construction and equipment standards to be used.



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Polio Patients Treated in General Hospitals

The treatment of infantile paralysis patients in general hospitals has not resulted in its transmission to other patients, according to the New York City Department of Health. In a recent letter, Dr. Frank A. Calderone, deputy commissioner of health, states that with 388 patients treated in general hospitals in 1944, "no secondary case of poliomyelitis as a result of exposure to a case treated in the wards of a general hospital came to our attention."

The advisory group on poliomyelitis of the city's health department recommends that "all patients in whom a diagnosis of anterior poliomyelitis is suspected should be cared for in a hospital and that these patients may be safely admitted to the general wards but that it might be desirable to separate the patients in special wards for ease in handling."



He's my little smoothie

How a mother in the hospital does look forward to those daily visits with her baby. Nothing escapes her attention—the color of his eyes, his chubby, little hands, his smooth, soft skin.

Naturally, baby's skin is given special attention in hospital pediatric routine. Many hospitals have found that 'Borofax', applied after every change of diaper and following baby's daily bath, helps to counteract the drying effects of soaps and powders, and to relieve the irritation caused by wet diapers. 'Borofax' is a soothing, protective, water-resistant ointment with 10 per cent boric acid in a bland emollient base, containing lanoline. In the maternity service, 'Borofax' provides an ideal dressing for fissured and cracked nipples of the nursing mother.

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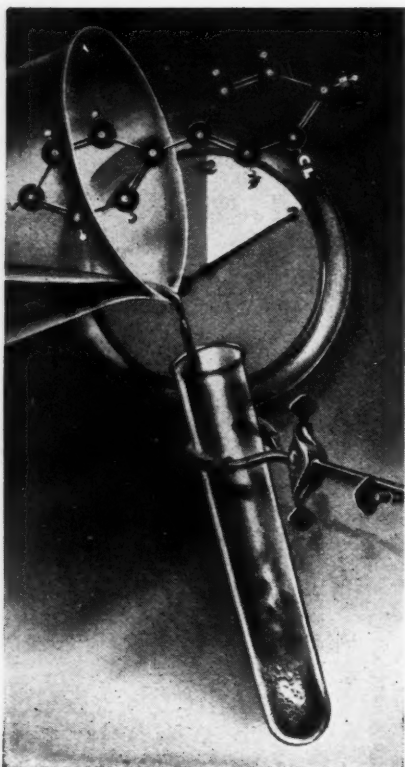
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Blue Cross Holds Regional Meetings; National Office Opens

The national Blue Cross enrollment office, scheduled to be opened on July 1 under the direction of Frank Van Dyk, actually opened on July 13 at 370 Lexington Avenue, New York City. Mr. Van Dyk will represent all Blue Cross plans in presenting a uniform program to national firms but local plans will continue to conduct all local transactions including enrollment and the payment of hospital bills.

To encourage national enrollment, all plans have agreed to waive requirements as to the minimum size of groups in enrolling branch office employees of national firms and to accept transfers from one plan to another.

Rhode Island reported that the 11,653 new subscribers whose contracts became effective on July 1 comprised the largest single month's enrollment this year and the greatest since the direct enrollment campaign was held last November.

Nine regional conferences of Blue Cross plans are being held throughout the United States devoted to enrollment and administrative problems. Each meeting is limited to conform with O.D.T. rulings.

"The present problem of Blue Cross plans calls for intelligent courage rather than impotent rage at the people's determination to do something about their own health and welfare," declared C. Rufus Rorem at the Philadelphia meeting. "We must multiply the number of subscribers who participate in voluntary plans, not the number of adjectives with which we describe our critics."

Santa Monica to Build

Santa Monica Hospital, Santa Monica, Calif., has received a federal grant of \$250,000 for the construction of a four story addition. The addition will cost \$560,000 and will add 143 beds to the hospital. The project also calls for making alterations in the kitchens, boiler room and engineering facilities, enlarging the operating room area and rearranging the x-ray, laboratory and emergency facilities. The new unit will include a complete new maternity section with broadcasting microphone in the delivery rooms connected with speakers in the waiting rooms.

Pays Tribute to Pharmacists

Dr. Ivor Griffith, president and research director of the Philadelphia College of Pharmacy and Science, paid tribute to the American Society of Hospital Pharmacists in a radio broadcast June 29 over the Blue Network in a program called "The Doctors Talk It Over."



Here's one way to Look at it...

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Commissioners Reject Proposal to License Practical Nurses

WASHINGTON, D. C.—A proposal to license practical nurses in the District of Columbia and place them under the nurses' examining board was rejected June 25 by the district commissioners. The proposal submitted by the Graduate Nurses' Association would require practical nurses to pay a license fee of \$10 a year and meet certain standards of character and mental and physical health.

Further requirements were that prac-

tical nurses must be not less than 20 years of age and must have three years' experience and work under the direct supervision of an M.D. or R.N.

The nursing board would have had jurisdiction over all practical nurses and authority to revoke licenses for such causes as negligence, intemperance, crime, immorality or fraud in procuring a license.

Wesley Begins Pastor Training

A five weeks' course in "Ministry to the Sick and Pastoral Counseling" began June 25 at Wesley Memorial Hospital in

Chicago with 10 pastors enrolled. The course is jointly sponsored by Wesley Memorial Hospital, Northwestern University Medical School and the Garrett Biblical Institute. The course will familiarize pastors with the modern hospital and its work, give them some insight into medicine and the work of the medical profession, teach them to work cooperatively with physicians and social workers and familiarize them with all aspects of the field of pastoral counseling.

Occupational Therapists Serve Army Hospitals

WASHINGTON, D. C.—Approximately \$18,000 worth of lumber, tools, copper, machine tools and other property, which has been declared surplus by various Army services and government departments, has been requested by the Reconditioning Consultants Division to be used for occupational therapy in Army hospitals, according to the surgeon general's office June 30.

The 92 members of the Occupational Therapy War Emergency Training Course who were graduated early in June have all been assigned to Army general and convalescent hospitals. Occupations taught may serve as the basis for a vocation or trade later on but they are not chosen for this purpose; they are prescribed by Army doctors according to their therapeutic value.

Urges Psychiatric Institute

WASHINGTON, D. C.—Sen. Claude Pepper of Florida has introduced on behalf of himself and Senators Thomas, Tunnell, Hill, Murray, La Follette and Aiken S. 1160 to establish a national neuropsychiatric institute. A similar bill in the house has been introduced by Rep. J. Percy Priest of Tennessee. The bills would foster research to provide more effective methods of diagnosis, prevention and treatment.

Announce New X-Ray Device

Intensive courses in the electronic aspects of the photo-timer, an ingenious new device for ensuring high-quality small film photographs of full-size x-ray images made at about one sixtieth of the cost of earlier methods, will be offered by 26 outstanding x-ray equipment engineers in various parts of the United States and Canada. This series of courses is to be provided in anticipation of the day when large-scale mass chest examinations will be made in all parts of both countries. The photo-timer was invented by Drs. Russell H. Morgan and Paul C. Hodges of the University of Chicago. It can be used for both small and large size x-ray film.



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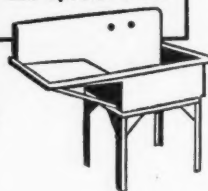
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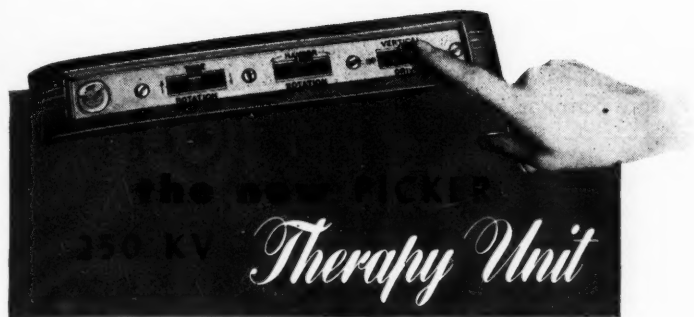
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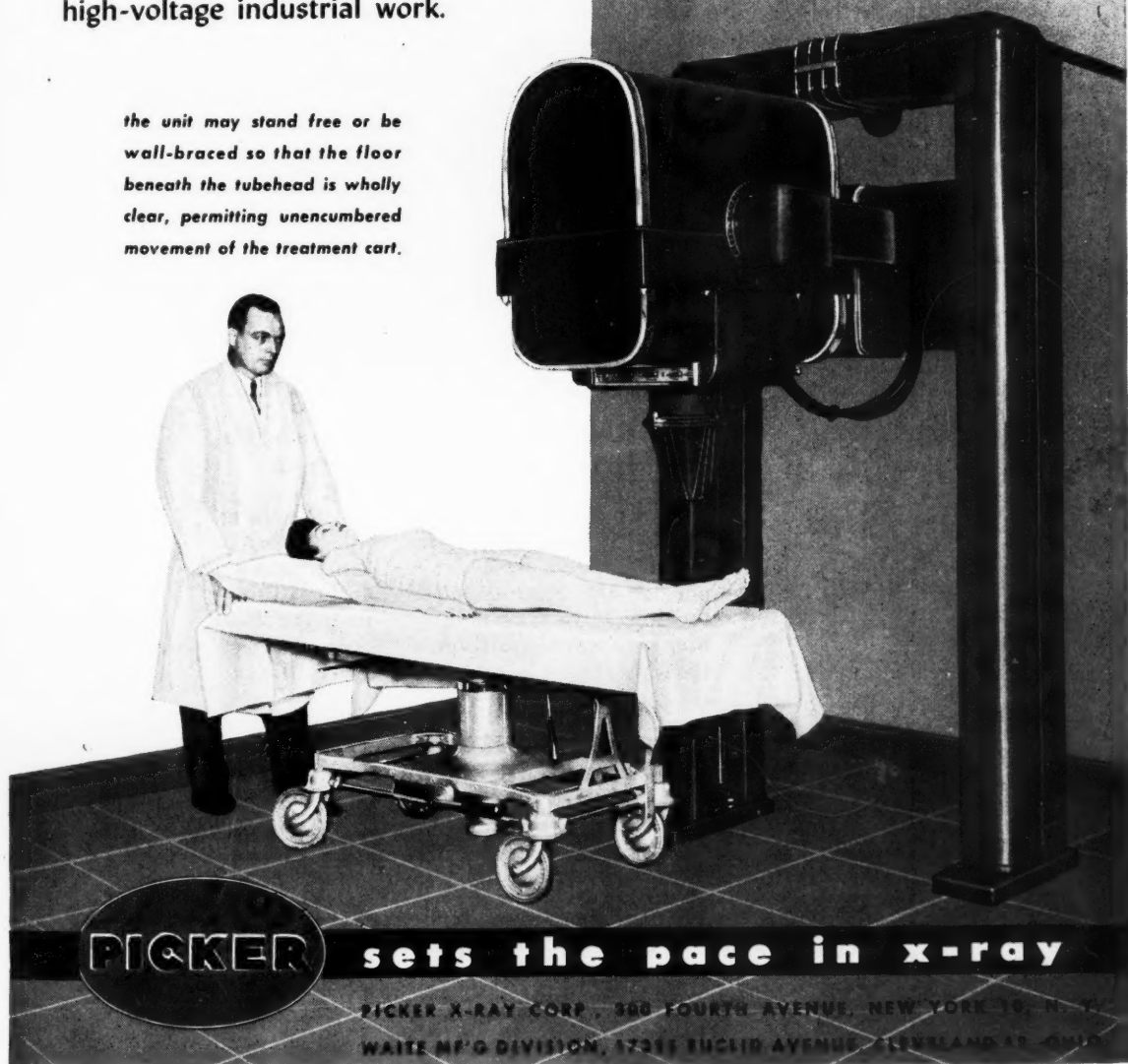




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clear, permitting unencumbered
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Myrtle McAhren Heads Illinois Association

Myrtle McAhren, administrator, Blessing Hospital, Quincy, was chosen president of the Illinois Hospital Association at a meeting of the board of trustees on July 14. She has been vice president and it was necessary to elect a president to succeed Frank W. Hoover who resigned when he left the state.

Stuart K. Hummel, Silver Cross Hospital, Joliet, was chosen first vice president. Other officers remain in office until an annual meeting can be held.

The Illinois association also decided to expand its services by employing Mrs. Florence Slown Hyde as assistant secretary to devote somewhat more than half of her time to the association. She has been editor of the association's bulletin and public relations secretary.

Rev. John W. Barrett reported that Governor Green had authorized the state health department to make a state-wide survey of hospital and health facilities as recommended by the Commission on Hospital Care. Dr. Henrietta Herbolzheimer, chief of the division of maternal and child hygiene, will be in charge. An advisory council will shortly be appointed by the governor.

Twenty-nine new institutional members were reported by Victor S. Lind-

berg, including all 13 state hospitals operated by the department of public welfare and the University of Illinois.

The trustees authorized a committee to cooperate with the state office of vocational education in developing training courses in human relations for hospital supervisory personnel.

Uniform Costs Deductible

The U. S. Commissioner of Internal Revenue has decided to abide by two tax court decisions which allow a deduction to nurses for the cost of their uniforms and the cost of laundering and cleaning them. Apparently, if a uniform is required in connection with work and has no other utility, its cost and upkeep are deductible from taxable income.

Revive Ambulance Plan

An intensive drive for improvement of ambulance service in Chicago, spearheaded by the Chicago *Sun*, has resulted in a revival of interest in the comprehensive report and program for adequate ambulance service prepared by a committee of the Chicago Hospital Council and medical groups some years ago. This committee, under the chairmanship of Dr. Malcolm T. MacEachern, prepared a program to provide ambu-

lance service to all parts of the sprawling city. The ambulances were to be housed in or adjacent to hospitals. No action was taken by the city council at that time on the plea of lack of funds. On July 17 Doctor MacEachern's committee reissued its report in printed form.

Modern Hospital Book of Plans Announced

Reservation orders for the *Modern Small Hospital and Community Health Center*, a 192 page book embodying the prize-winning and other plans submitted in The MODERN HOSPITAL's architectural competition, are now being accepted according to an announcement on July 25.

There are six prize-winning plans of small hospitals and 29 other small hospital plans in the book. For small community health centers there are six prize-winning plans and three other plans. Each plan has a statement by the contestant and a comment by the jury or the editor.

In addition to the plans, the book contains an introduction by Dr. Thomas Parran and articles on the need, the community survey, the consultant, architecture and design, organization and finance, professional organization, administrative organization, patients' needs and a check list of equipment.



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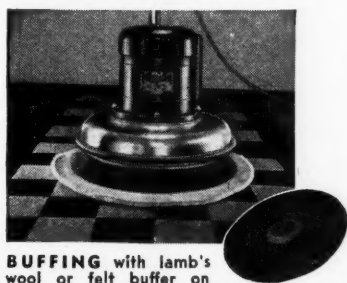
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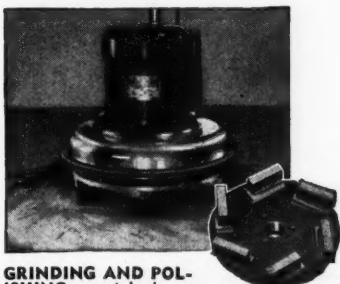
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New Hampshire Adopts State Plasma Program

Plans for the development of a state-wide plasma processing program under the direction of the University of Vermont Medical School and the Mary Fletcher Hospital at Burlington and for the hospital care of infantile paralysis patients in case of an epidemic were formulated and adopted by the New Hampshire Hospital Association at its annual meeting at Portsmouth Hospital on July 14.

Maud Miles, president, reported on a preliminary survey of personnel practices in the state's hospitals. After consultation with representatives of the state nurses' association, a code of personnel practices will be recommended to all the hospitals of the state.

It was decided to allow active members of other state hospital associations to transfer membership to the New Hampshire Hospital Association without payment of dues for the remainder of the current year.

Miss Miles, Peterboro Hospital, was reelected president. Other officers are vice president, Sara Nicholl, R.N., Exeter Hospital; treasurer, Mrs. Mabel Parsons, Elliot Hospital, Keene, and secretary, Mrs. Anne MacDougall, Memorial Hospital, Nashua.

I.-A.H.A. May Move Office

The Inter-American Hospital Association is considering the idea of moving its headquarters from Washington, D. C., to Mexico City. Dr. Gustavo Baz, president of the association, lives in Mexico City and has raised a considerable sum of money there for the support of the association and also has obtained space for a headquarters. Felix Lamela, the executive secretary, has made several trips to Mexico City.

The association is now housed in a building with the hospital facilities section of the U.S.P.H.S. on Dupont Circle in Washington, D. C. This office may be kept open, even if new headquarters are opened in Mexico City. The association recently completed its incorporation in Delaware.

W. Va. Officers Elected

E. A. Groves, Kanawha Valley Hospital, Charleston, W. Va., was inducted as president for the coming year of the Hospital Association of West Virginia. B. B. Dickson, Stevens Clinic, Welch, was named president-elect; C. C. Warner, Mountain State Memorial Hospital, Charleston, is the new vice president, and Charles E. Vadakin, Fairmont General Hospital, Fairmont, is secretary-treasurer.

A.H.A. Program Seeks to Mobilize Personnel

A program for mobilizing personnel for hospital employment is being developed by the Office of War Information and the War Advertising Council in cooperation with the American Hospital Association and will probably start within the next few weeks. It will make extensive use of newspapers and radio to enlist additional employees, according to George Bugbee.

A new motion picture bearing the tentative title of "Do Unto Others" will soon be ready for release to hospitals for their programs of educating personnel. It has been prepared with aid from a grant from the Becton Dickinson Foundation.

Jack Williams, former business manager of *Hospitals*, has been appointed business manager for the entire A.H.A. with continued responsibility for the magazine's advertising and business policies.

A.C.H.A. Issues Roster

The 1945 roster of membership of the A.C.H.A. has just been published. The roster contains an alphabetical arrangement of names and a combined geographical classification and index.

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Canadian Association Issues Book of Plans

In response to many inquiries on planning hospital construction, the Department of the Hospital Service of the Canadian Medical Association has published a booklet called "Planning and Constructing the General Hospital."

The section on planning of services and departments refers to a hypothetical hospital of about 200 beds, to permit inclusion of the various features of a general hospital. Floor plans and pictures are included in the descriptions.

The medical association, in planning the booklet, hopes that it will be of help to building committees in working out the first steps in planning the various departments of the hospital.

Tuberculosis Carriers Sentenced

Two tuberculosis carriers in Washington, D. C., have been sentenced for refusing to accept hospitalization. A veteran of World War I was ordered to serve seven months in prison as a hospitalized patient, in lieu of a \$100 fine and a thirty day jail sentence. The second carrier, a housekeeper who had infected a child of one of her employers, was given a year's parole in a hospital in place of a \$100 fine and a thirty day prison sentence on the charges that she had evaded hospitalization since April.

Plan Pays \$14,000,000

During the last six and a half years, the Associated Hospital Service of Philadelphia has paid more than \$14,000,000 to hospitals for the care of subscribers. During June of this year, a total of \$359,627.93 was paid. The check which pushed the total over the \$14,000,000 mark went to Hahnemann Hospital of Philadelphia, 20 per cent of whose cases are Blue Cross subscribers.

Flint Hospital Over Goal

With subscriptions totaling \$448,427, the campaign for the construction of a new nurses' school at St. Joseph's Hospital at Flint, Mich., ended July 6, \$23,427 over its mark. Plans for the new school, on which construction will begin just as soon as materials and labor are available, include four stories of classrooms, laboratories, lecture rooms and living and recreational quarters for 100 student nurses.

Medical Department Celebrates

WASHINGTON, D. C.—The Army Medical Department, organized in 1775, celebrated its 170th anniversary July 27. Grown into one of the largest organizations of its kind ever known, this department has made steady progress in military medicine and scientific discoveries that have benefited all mankind.

Seek \$900,000 for Psychiatric Wing

A campaign for \$900,000 for a psychiatric wing for the Norton Memorial Infirmary, Louisville, Ky., is the largest sum of money ever asked of that city except for the war fund.

It is proposed to erect a six story building, at least half of which will be used for psychiatric work. Other enlargements will affect the kitchen, power plant, laundry and out-patient clinic.

A major innovation for Louisville is an inclusive rate charge for the psychiatric department.

Arkansas Names Officers

New officers elected by the Arkansas Hospital Association for 1945-46 are: president, Helen Robinson, University Hospital, Little Rock; vice president, John O. Steel, Davis Hospital, Pine Bluff; secretary, Marguerite LeGrande, Trinity Hospital, Little Rock; treasurer, Mrs. M. S. O'Neal, Lake Village Infirmary, Lake Village, and trustee, John A. Rowland, Trinity Hospital, Little Rock.

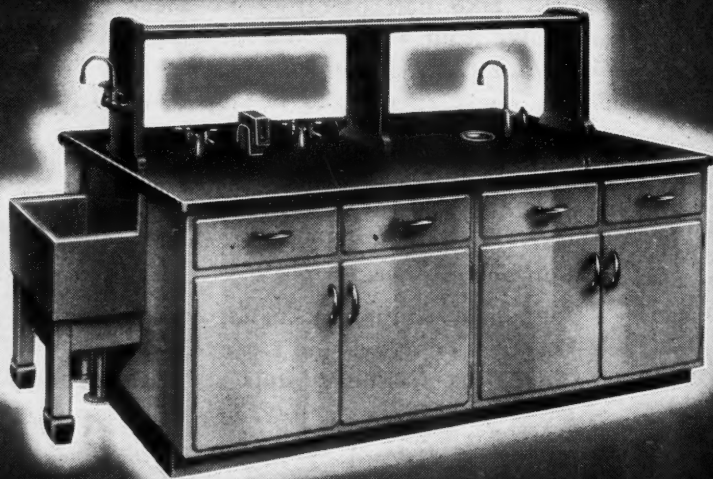
Newton Changes Name

The official corporate name of Newton Hospital, Newton Lower Falls, Mass., has been changed to Newton-Wellesley Hospital.

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Seek Establishment of Army Optometry Corps

WASHINGTON, D. C.—H.R. 3755, introduced in the House July 11, seeks to establish an Optometry Corps in the medical department of the United States Army. Hearings have been in progress on H.R. 1699 which would also establish an optometry corps in the Army. In spite of opposition on the part of the War Department to the earlier bill, the proposed new legislation has been reported by the committee.

Opponents of the bill claim that optometrists do not have sufficient professional preparation. Advocates claim that all the states and the District of Columbia require optometrists to have at least a high school education in addition to a four year course in an accredited optometry college.

Iowa Hospital Reorganized

After many years of discussion and effort, the Atlantic Hospital, Atlantic, Iowa, has been reorganized as a non-profit corporation effective July 3. Previously the board of trustees was composed exclusively of physicians. Now the board includes a banker as president, another banker as vice president with two other laymen and seven doctors on the board. Lilyan Zindell is superintendent.

Chaplains' Corps for V.A.

WASHINGTON, D. C.—Rev. Crawford William Brown, who recently became chief of the Chaplains' Service in the Veterans Administration, will be responsible for organizing and staffing the Chaplains' Corps. His new parish will consist of the 97 veterans' hospitals with about 90,000 patients. At least one full-time chaplain will be employed in every hospital with as many as 500 patients. Smaller hospitals will have part-time chaplains and larger staffs will supply the big hospitals.

Mr. Brown was a captain in the Army Chaplains' Corps in World War II. In World War I he served as a private in a machine gun battalion in France.

Hospitals' Obligations Outlined

The four-fold obligation of hospitals to the communities they serve was outlined by Everett W. Jones, vice president, The Modern Hospital Publishing Company, at a meeting of the Northern Michigan Hospital Council at Petoskey, July 12. The obligations fall into the fields of public health, high grade hospital and medical care, research and education. He pointed out that the foundation of a good public relations program is a sound employee-employer set-up plus a staff of enthusiastic doctors.

U.S.P.H.S. Corps Is Military Service

WASHINGTON, D. C.—Effective July 29 for the duration of the war an executive order makes the commissioned corps of the U. S. Public Health Service a military service and a branch of the land and naval forces of the United States. The order does not affect the administration of the Public Health Service. Commissioned officers of the service will have the same status under the order as members of the Army, Navy and Coast Guard and will be subject to the same discipline and obligations. Postwar status of these officers will be the same as that of all veterans.

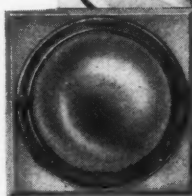
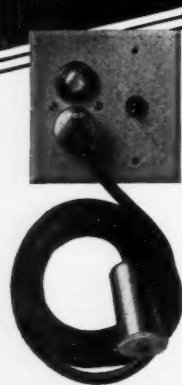
Increase Medical Corps Pay

Medical officers and enlisted men who have served with the troops under enemy fire and are entitled to wear the medical badge are to receive additional pay, corresponding to combat pay, at the rate of an increase of \$10 per month, under H.R. 2477 passed by the House in June.

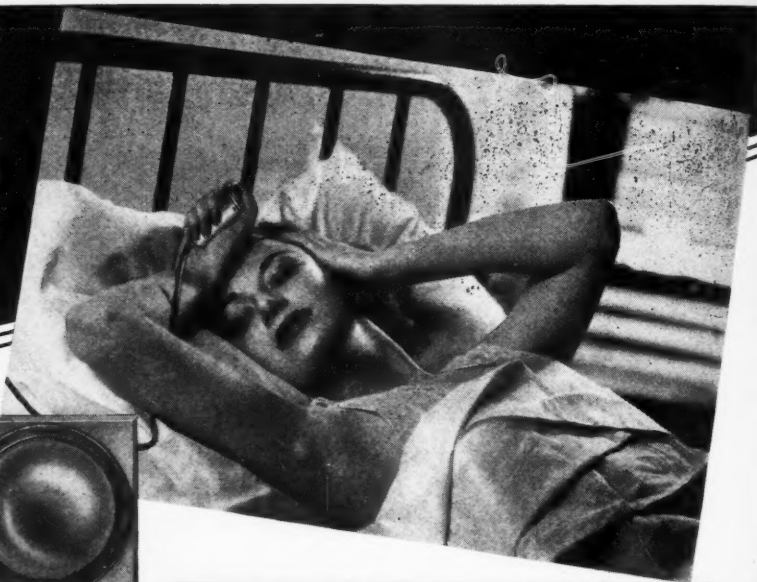
N. Y. Hospitals Consolidate

New York Orthopaedic Dispensary and Hospital, New York City, has been consolidated with Columbia-Presbyterian Medical Center. The merger will give Presbyterian Hospital a complete orthopedic service, it was stated.

Hospital SIGNALING Systems



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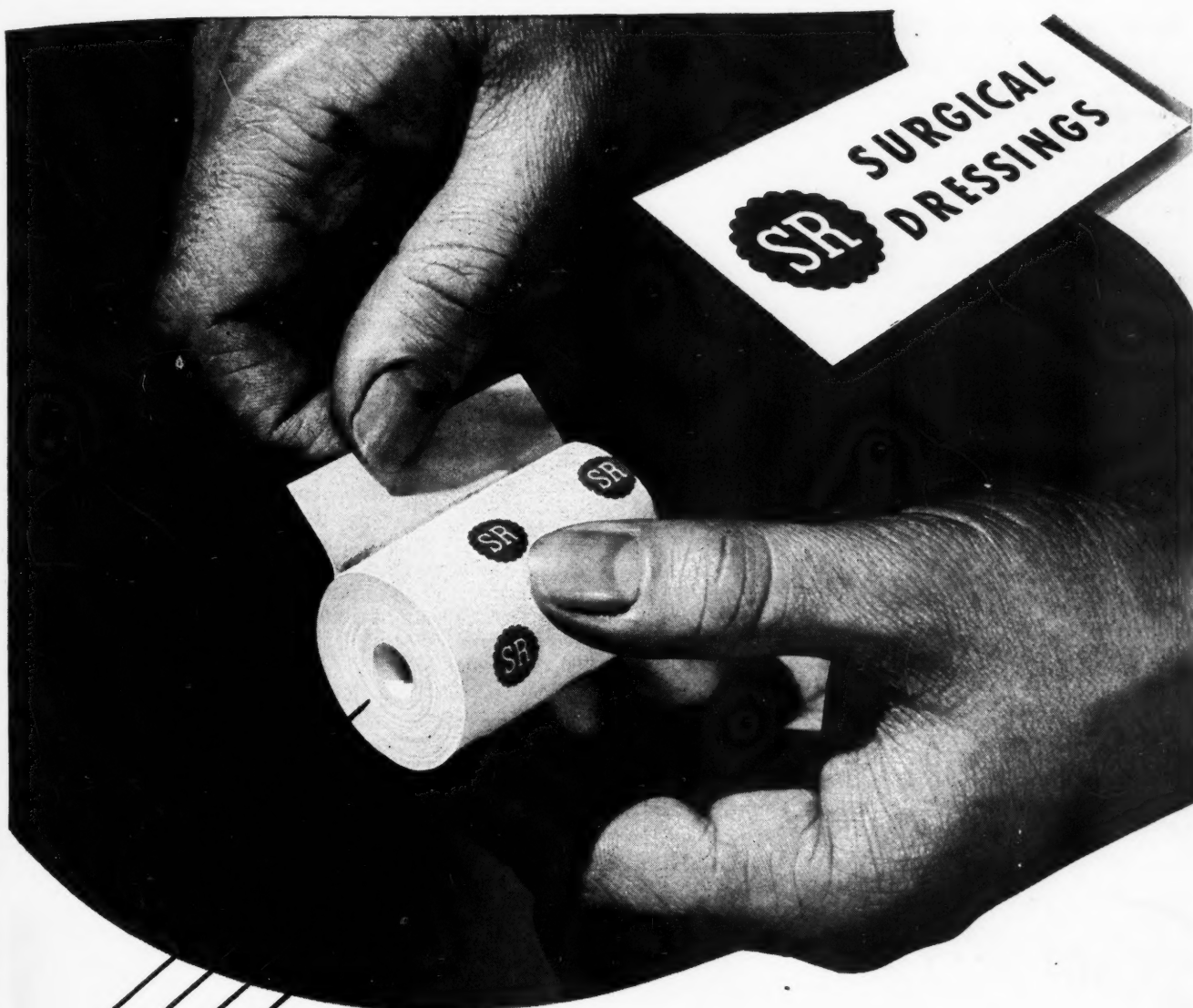
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"SR" READY-CUT BANDAGE ROLLS with the *Non-Ravel Edge*

A mechanical process . . . not a chemical treatment . . . accounts for the non-ravel edge of "SR" READY-CUT BANDAGE ROLLS. This specially prepared edge eliminates loose threads and assures a bandage of long lasting neatness.

Another important feature is the improved ready-to-pull paper tab. One quick pull instantly removes the protecting wrapper.

"SR" READY-CUT BANDAGE ROLLS are available in 1", 1½", 2", 3", and 4" widths. Order them from your Hospital Supply Dealer.

Gauze Sponges • Absorbent Gauze (100 yds.) • Cotton Pound Rolls • Cotton Balls • Post-Operative Dressings • Adhesive Plaster, U. S. P. • Cut-Rak Adhesive Dispenser • Gauze Bandage Rolls • Absorbent Cellulose • Unbleached Muslin • Maternity Pads • Gauze Bandages, U. S. P. • Sur-Pads • Package Gauze • Absorbent Cotton, U. S. P. • Stick-Bands.

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American Longevity Decreases

The average length of life of the American people in 1943, as computed from the mortality then current and announced recently by the Metropolitan Life Insurance Company, was 64½ years, one third of a year less than the peak reached in 1942. These figures are based upon the entire population within the United States, both civilian and military, but exclude experience overseas. The slight decrease in longevity was due largely to the influenza epidemic, to the withdrawal of the healthiest males into overseas service and to increased accidents, especially in military aviation.

Since 1900 the increase in total life expectancy has been 15 years for white males and 17 years for white females. For colored males the increase has been 22 years and for colored females, 23 years but the colored still have an average life span about 10 years shorter than the whites.

Enroll 750,000th Subscriber

Matthew Weisman of Philadelphia, a former staff sergeant in the Army Air Forces, was enrolled as the 750,000th subscriber of the Associated Hospital Service of Philadelphia. He was presented with a war bond by the plan.

Endorse Physical Fitness Program

A platform and an educational program for a nationwide physical fitness movement drawn up by the A.M.A. and the Federal Security Agency have been endorsed by the National Committee for Mental Hygiene. Dr. George S. Stevenson is chairman of the committee to set up a platform of mental hygiene for recommendation to educational systems throughout the country. The proposed educational program to protect the health of every child from the time he starts to school includes preadmission physical examinations, education in principles of hygiene and healthful living and provision for adequate personnel and facilities.

Dormitory to Open in Fall

Catholic University, Washington, D. C., expects to have its three story dormitory for nurses ready for occupancy by the beginning of the fall term. The structure will have 100 rooms and will contain a dietetic laboratory, cafeteria and conference rooms. Of the total cost of \$240,000, the federal government has allotted \$156,000 under legislation which sets up a fund for training nurses for service in the armed forces and the public health service.

Goldwater Fellow Appointed

The first S. S. Goldwater fellow in hospital administration to be appointed by Mt. Sinai Hospital, New York City, for one year of study and observation at that hospital has been announced by Dr. Joseph Turner as Dr. I. Norwich, M.B., F.R.C.S. (Edinburgh), now assistant superintendent of Johannesburg Hospital, Johannesburg, South Africa. Doctor Norwich will arrive in the fall. He is a native of Johannesburg and has carried on graduate medical study in England.

McKeesport Plans Addition

McKeesport Hospital, McKeesport, Pa., has started a campaign to raise \$600,000 for an addition to increase the hospital's bed capacity from 325 to 443 beds. Plans for the new wing, construction of which will probably start within a year, call for at least eight stories with the greatest increase in private and semi-private rooms.

Ravenswood to Build Wing

Ravenswood Hospital, Chicago, is planning the construction of a \$750,000 five story building with between 85 and 100 beds, bringing the institution's capacity to 250 beds. The new building will permit expansion of laboratories, x-ray and physical therapy facilities.

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Yes, from any angle Hillyard Floor Treatments **SAVE YOUR FLOORS**, they give surface protection, non-slipperiness, long wearing, easy maintenance and are economical. In every classification Hillyard's Floor Treatments, Seals, Finishes, Waxes, Cleaners and Sanitation Materials give complete satisfaction.

Besides the extra quality and value in its products Hillyard's maintain a Nation-wide Service of Floor Treatment Engineers . . . there is one in your community and his advice is freely given on any floor treatment or maintenance problem. Call or wire us today.

If you have not received a copy of Hillyard's new book "Floor Job Specifications," write for your copy today, it is **FREE** and full of real help on economical Floor Treatment, showing proper materials and labor-saving methods.

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A NOTEWORTHY ADVANCE IN DERMAL SUTURES

The *Champion Dermal Suture* provides the following six essential advantages:

1. softness and pliability for ease in handling
2. non-adherence to skin
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The unique qualities of *Champion Dermal Sutures* make them ideally suited for all forms of surface surgery, including the most delicate plastic suturing. Made in a fine diameter, these sutures leave a minimum of scar tissue.

Champion Dermal Sutures are made of the finest quality silk, by the exclusive Gudebrod process. Their manufacture is under the same rigid laboratory control exercised in the making of *Champion-Paré Serum-Proof Sutures*, the choice of leading surgeons for all forms of buried suturing.

Free operating lengths of either or both types of sutures will be sent on request.



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MANY SURGEONS NOW PREFER THE MINTRAUMATIC SUTURE—NEEDLE SWAGED TO END OF A SINGLE STRAND. WRITE FOR INFORMATION.

Physical Therapists Trained

Albany Hospital, Albany, N. Y., has opened a new course for physical therapists to be given twice yearly in September and in March. The course consists of didactic lectures and practical work carried out in the Albany Hospital and Medical School and will last nine months, with a preclinical course of three months and a clinical course of six months.

Ship Named for Nurse

Renamed the *Frances Y. Slanger* in honor of the first American nurse killed in the European theater, the former Italian luxury liner *Saturnia* has joined the Army's hospital fleet as the world's largest and fastest vessel for transporting the sick and wounded home from world battlefronts. The 24,500 ton ship has provisions for 1776 patients.

Licensing Council Named

Dr. E. H. Clauser of Muncie, Ind., has been chosen to head the advisory council to the Indiana State Board of Health in the administration of the hospital inspection and licensing law. The council held its first meeting on May 25. The following hospital people are members of the eight member commission: Albert G. Hahn, J. B. H. Martin, Sister M. Amelia and Mrs. Olive Murphy.

Survey Film Equipment

The motion picture bureau of the Metropolitan Life Insurance Company's welfare division recently sent a questionnaire to 1329 schools of nursing on film equipment available in their schools. Of the 799 that replied, the survey revealed that 16 millimeter is the most popular size for both sound and silent motion picture projectors and that motion picture projectors far outnumber film strip and slide equipment.

Fund Collects \$4,038,297

During its eighth annual campaign, the Greater New York Fund collected \$4,038,297 in contributions from business concerns and employe groups. At the fund's third report luncheon held at the Roosevelt Hotel recently, "quota buster certificates" were given to the chairmen of 69 divisions which had reached or passed their quotas.

Medical Economics Reference

A selected bibliography on medical economics was published on May 28 by the Social Security Board as Memorandum No. 60. It was compiled by Helen Hollingsworth and Margaret C. Klem. Sections cover health status, expenditures for medical care, medical facilities, public health and industrial medical care.

New Pawating Hospital Opened

The new 52 bed Pawating Hospital at Niles, Mich., was officially opened recently and citizens were able to inspect the new operating and delivery rooms, together with x-ray and other laboratory and service facilities. Pawating Hospital will house a complete hospital unit and an additional 18 beds will be provided as soon as remodeling of the old structure is completed.

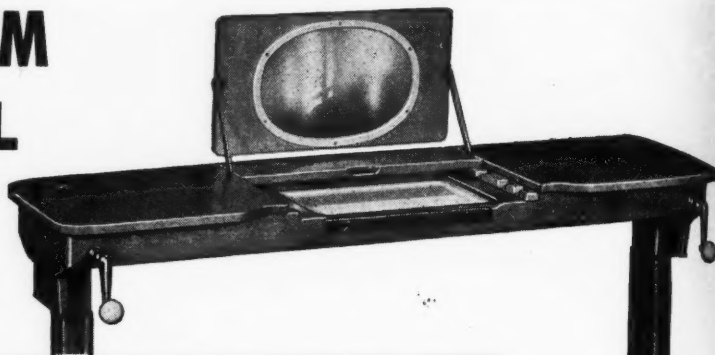
Install Electron Microscope

The National Cancer Institute, Bethesda, Md., has installed a \$13,000 one ton electron microscope powerful enough to magnify the windpipes of mosquitoes to a size of approximately 2 inches. In addition to the study of cancer, the microscope will be available to other divisions of the National Institute of Health.

Plan Opens Branch Offices

Branch offices of the Plan for Hospital Care, Chicago, have been opened on the south, west and north sides of the city and in the following near-by cities: Evanston, Oak Park, Waukegan, Elgin, Aurora, Joliet and Harvey. Each of them is under the direction of a manager. The headquarters office recently moved to 11 South La Salle Street.

This Beautiful HILL-ROM DOUBLE PEDESTAL VANITY OVERBED TABLE



Again Available in Pre-war Construction

This popular double pedestal overbed table, No. 414, for use on standard 3' 3" hospital beds, is again available in all its pre-war beauty and quality. Easily adjustable to any position the patient requires, this table can be used for eating, reading, writing, dressing, shaving, playing cards, etc. Or, it may be used as a flower table

when removed from the bed. A great convenience to patient and nurse alike. Crank handles for adjusting height are conveniently located at the front of the table. The reading rack is adjustable to various angles.

Write for complete information and prices on this and other Hill-Rom Overbed Tables.

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In these days especially, this simplicity of control is valuable in directing inexperienced employees, saving time and assuring accuracy.

Stormont Hospital has also taken the wise precaution of "guarding its income" against fire loss—its collection records are housed in *certified* Safe-Cabinets. Thus full protection is combined with maximum convenience of posting and reference, and labor is reduced to a minimum.

Why not let a Systems Technician show you how better record control can serve *your* institution? Just call or write our nearest Branch Office.

Hospitals save labor, simplify routine with **KARDEX** Record Controls

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Patients' Histories	Nurses' Record
Floor Records	Ledger Records
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...and others are designed to meet any requirements and assure increased efficiency of operation.

SYSTEMS DIVISION
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ABOUT PEOPLE

(Continued From Page 78)

cago. Mr. Davison's death was announced in the July issue.

Harry Dunham, formerly purchasing agent and administrative assistant at Barnes Hospital, St. Louis, has accepted the post of purchasing agent at Miami Valley Hospital, Dayton, Ohio.

Ethel A. Wilbur has been named director of nurses at Bloomsburg Hospital, Bloomsburg, Pa.

Mrs. Ella Johnson, formerly associated with the Shoreland Hotel in Chicago, has been appointed housekeeper at Passavant Memorial Hospital in Chicago.

Miscellaneous

Samuel E. Lunden, who collaborated with Louis Dixon on the prize-winning plan for the health center in the competition by *The Modern Hospital*, was recently awarded a fellowship in the American Institute of Architects.

Lillian J. Johnston, commissioned as nurse officer (reserve) in the U.S.P.H.S., has been appointed chief nurse, health

division of U.N.R.R.A. Since March 1944, Miss Johnston has been serving as acting chief nurse. She will maintain contact between U.N.R.R.A. and other organizations concerned with nursing.

Dr. D. B. Wilson, surgeon in the U.S.P.H.S., has joined the staff of the Commission on Hospital Care as assistant director replacing **Dr. Robert C. Morrey** who has been assigned to active sea duty.

Lois Frumkin, a recent Radcliffe graduate, has been appointed assistant to Alfred Marshall, public relations director of New Haven Hospital, New Haven, Conn. She assumed her new duties on August 1.

Alden B. Mills to Enter Administration



On October 15, *The Modern Hospital* must bid reluctant farewell to its managing editor, Alden B. Mills, who will become the administrator of Collis P. and Howard Huntington Memorial Hospital, Pasadena, Calif., succeeding

Alice G. Henninger, whose resignation was announced last month.

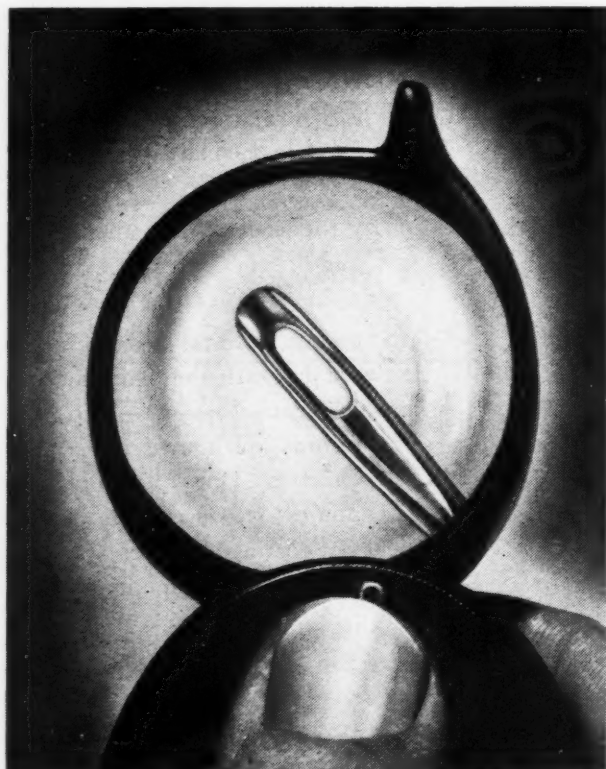
Special tribute to Mr. Mills' contribution to this magazine and to hospital thinking will be paid in a later issue.

Mr. Mills has served this magazine as managing editor for twelve years during which time he has become a national figure through his writings, his personal contacts and public addresses, and his work on A.H.A. and other committees and projects.

He entered the hospital field proper after five years as executive secretary and member of the research staff of the Committee on the Costs of Medical Care.

Public relations and personnel relations are Mr. Mills' two outstanding interests in the hospital world. His book, "Hospital Public Relations," is the standard work. His liberal thinking on personnel relations and his aid in the rebirth of the Bacon Library are two of his foremost contributions to the A.H.A. He is chairman of the committee on poll of current issues of the A.C.H.A.

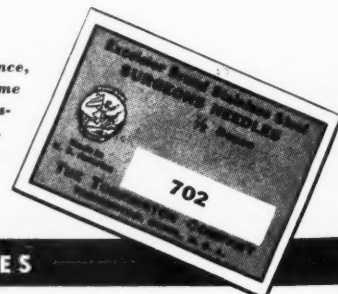
Mr. Mills has also put his analytical mind and well-developed social conscience to use in many activities outside the hospital field. He is president of the Illinois Association of School Boards and a member of the school board in his own city of Evanston, Ill., where he is also president of the Evanston Council of Social Agencies.



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Torrington Surgeons Needles display accuracy of workmanship developed by nearly 80 years' experience in needle manufacture . . . plus stainless steel protection from rust and corrosion. Specialized Torrington techniques assure uniformity of size and shape . . . special Torrington heat treatment assures uniformity and perfection of temper. Ask your hospital supply distributor for more information on the 34 popular styles and 149 sizes.

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- Easier cleaning** when finally necessary, because of the wax. Film retains its gloss—resists caustic cleaners.
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Coming your way! Though not available today, this wax-fortified finish will be supplied just as soon as war restrictions on certain materials are lifted. Now is the time to get all the facts!

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Wax impregnation—that's the difference—and that's why Johnson's Wax-Fortified Interior Finish gives you these important advantages! Wax-Fortified has wax *all through* the film. Its rich wax lustre lasts as long as the finish remains—doesn't dull when washed or cleaned, and is easier to clean when necessary. Light reflection values—high at the start—remain high, yet don't cause glare, because light rays are diffused.

Higher maintenance efficiency — lower maintenance costs

Wax-Fortified is a superior finish—a different finish that gives greater beauty and extra protection. It is made in white and a variety of colors that have broad coverage and great hiding power.

Refinishing is easy

When refinishing is finally necessary, the wax in Wax-Fortified does not retard adhesion, and no special cleaning is required. You can recoat with Johnson's Wax-Fortified, or with ordinary paint.

Bakeries, food plants, dairies, factories, office buildings, department stores, schools and hospitals will find Wax-Fortified a boon to solving their painting problems. It will give them a better finish and greatly simplify maintenance.

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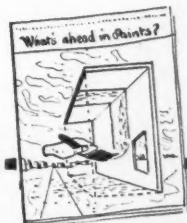
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OFFICIAL ORDERS

June 15 to July 19

Atabrine.—On July 12, W.P.B. reported that an adequate supply of antimalarial medication was available for civilian medication needs. There is no quinine for oral use but it may be had in ampule form for parenteral use when required.

Blankets.—Direction 4 to M-73 which froze 100 per cent of the blankets and blanketing to rated orders only has been revoked, according to an announcement of the War Production Board July 6. Revocation of the freeze came because of the Army's reduction of 5,000,000 yards in its wool blanketing requirements for July, August and September. This reduction will assure civilians of an ample supply of blankets this winter.

Chemicals.—Military requirements for amyl alcohol, amyl acetate and synthetic camphor have been so sharply reduced that W.P.B. has transferred them to Order M-340 from M-300—thus putting them under general allocation rather than direct allocation control. At the same time, Schedule 75 (synthetic camphor) and Schedule 100 (amyl alcohol and amyl acetate) were revoked.

Chicken.—W.F.A. has asked processors to give preference to civilian hospitals when increased quantities of chicken appear in the eastern markets as a result of modification in the operation of W.F.O. No. 119. The action took effect June 25 in Delaware, Maryland and Virginia and is expected to be extended to other major chicken producing areas now under the order.

Electric Fans.—Order L-176 was amended on July 14 to permit the unlimited production of electric fans as defined in the order, but their delivery is still restricted. Hospitals may obtain fans as authorized by W.P.B. on Form WPB-1319.

Electric Motors.—Limitation Order L-341 and all outstanding authorizations issued under it were revoked July 14.

Hearing Aid Batteries.—Amendment No. 1 to MPR No. 576, effective July 23, says that all except war models will be held at retail to the March 1942 prices. L-71-a has now been revoked and some new styles may be produced, O.P.A. said.

Insecticide.—On July 12 W.P.B. announced that greater quantities of DDT would be required by the military in the Pacific areas. Limited quantities will be available for experimentation for civilian purposes and one commercial use has been authorized. Application for DDT for experimental purposes must be made in accordance with paragraph (f) of the General Chemicals Allocation Order, M-300.

Mattress Inner Spring Units.—Ceiling prices have been established for base models, although units are not yet being produced on a large scale, the O.P.A. announced on June 23. The new prices represent March 1942 price levels generally.

Oil.—Amendment No. 59 to Revised Ration Order 11 became effective June 29. This limits users of residual fuel oil in the Midwest to two thirds of their normal requirements for heat and hot water.

Paper Cups.—An amendment July 13 to Order L-336 (which limits the manufacture, delivery and use of certain sanitary food containers) requiring the furnishing of a certificate to the manufacturer for each delivery of hot drink cups does not affect hospitals, according to the hospital unit, W.P.B. Such institutions may still use their MRO ratings in ordering hot drink cups.

Paper milk containers and liquid tight paper containers are removed from the list of sanitary food containers covered by the order. The following remain under various restrictions of the order: empty round nested containers made of paper or paperboard, empty open nested paper cups except those of the flat envelope type, hot drink cups, cold drink cups, hot food cups and flat bottom paper dishes.

Plumbing, Heating and Cooking Equipment.—Order L-79 was amended June 29 with the intent of conserving the supply and directing the distribution of such equipment. These items are available to essential users only.

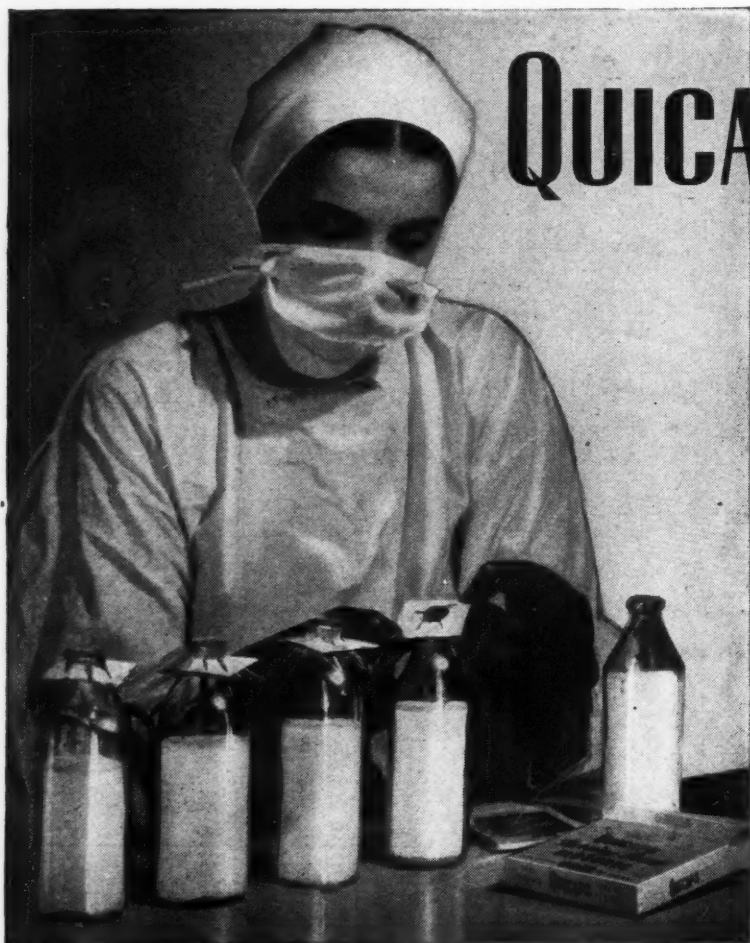
Rationing.—Under changes announced by O.P.A. on July 19, any licensed practitioner may certify applications for extra food rations needed in case of illness. This includes chiropractors, if they are authorized by the laws of the state in which they practice to diagnose and treat the illness for which certification is made. The diseases approved for additional food are: diabetes, tuberculosis, chronic nephritis, cirrhosis of the liver, chronic suppurative diseases, burns, gastro-intestinal lesions, pregnancy and lactation.

Rubber Flat Goods.—Effective June 26 two changes were made in ceiling prices. Specific ceilings for combination syringe attachment sets and invalid rings and cushions are discontinued while ceilings for molded ice caps will apply only to those sold at a net price of from 44 to 48 cents each by manufacturers.

Sugar.—Amendment 107, effective July 3, simplifies and clarifies provisions governing home canning by institutional users. A limitation is placed on the amount of sugar to be granted for the purpose of producing jams, jellies, preserves, marmalades and fruit butters because of the tight sugar supply situation. There is no real change for hospitals generally in the new amendment but eleemosynary institutions are advised to take advantage of Section 28.7 of home canning regulations of GRO 5.

Textiles.—O.P.A. on June 21 gave manufacturers of certain cotton textile goods the right to contract with their customers for adjustable pricing on goods whose production costs will be higher because of higher wages authorized by W.L.B. This means that at a later date the manufacturer may collect from his customers the price increases eventually ordered by O.P.A.

Vitrified Chinaware.—Production is not keeping pace with the increasing need, principally because of a shortage of the necessary materials. On June 23, W.P.B. announced that three southern plants which produced clay for rubber and paper manufacture had been destroyed by fire and so there was a temporary diversion of china clay production facilities to rubber and paper clay production. Because of limited shipping space, imports of English china clay dropped. Durable, sanitary chinaware is a real need and every effort is being made to provide the industry with the materials for manufacture.



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CLOSURES

Make This Test

If you are still using old-fashioned rubber or glass caps to seal infants' nursing bottles—do this:

Seal 5 bottles with the type cap you are now using. Then . . . seal 5 bottles the Quicap way—handy Quicap collars over disposable Cellophane covers.

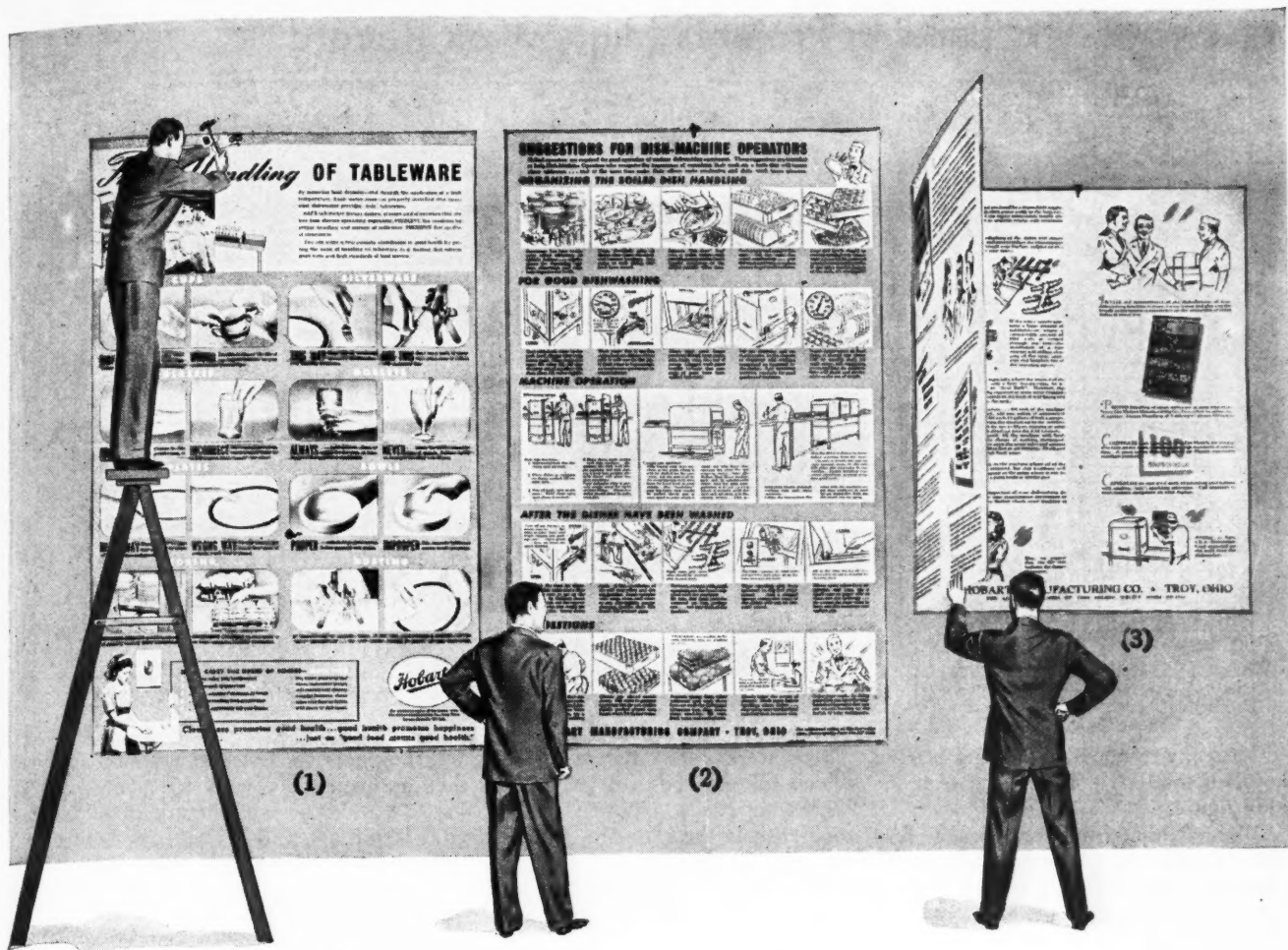
Notice how easy, and *quick*, the Quicap method is. Just three simple motions and the bottle is sealed—tight, germ-proof. No more broken fingernails . . . no collecting to sterilize . . . no spilled formulas.

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Here are three short-cuts to lower overhead and better service—three free guides to time-conserving, money-saving dishwashing efficiency. Every one is designed to promote better food service. Put them to work and see for yourself!

Tack up the two wall charts (1 and 2 above) in the dish pantry and watch your present equipment produce better results. Both are full colored, poster size on heavy stock. They show in pictures "Suggestions for Dish Machine Operators" (1);

and "Proper Handling of Tableware" (2). The folder (3) is a file-size gold mine of "Suggestions for the Kitchen Manager—Clean Dishes at Lower Cost." You'll use it again and again.

Write us for as many free copies as you wish whether you use Hobart dishwashers or not. If you would like to talk kitchen equipment with the leading manufacturer of Food Machines of every kind, see your Hobart representative, or write the factory.

WRITE for your free copies to the Hobart Manufacturing Co., Dishwasher Division, Troy, Ohio. For "Suggestions for Dish Machine Operators" (1) request release ED3145; for "Proper Handling of Tableware" (2) request release ED1145; for "Suggestions for Kitchen Managers" (3) request release ED3245. Please write at once to insure getting your copies. No obligation.



The Hobart

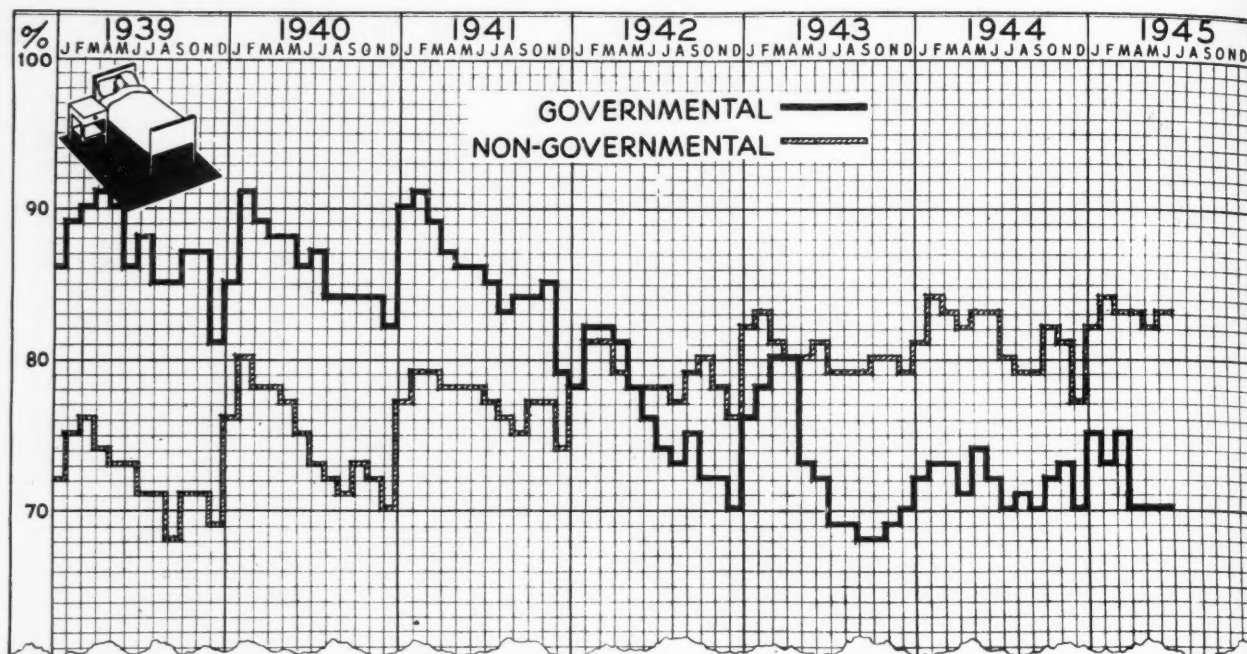
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Building Projects Highest on Record



Occupancy in nongovernmental general hospitals rose one point in June over the May figure.

A tremendous amount of new hospital construction (or projects once postponed and now revived) was announced in the period from June 11 to July 23.

There were 148 different projects, of which 137 gave costs of \$68,712,000, the largest total cost reported in any one month since these reports were started. This brought the total since January 1 to \$154,905,000.

During the period, there were 27 new

hospitals to cost \$24,306,000; additions numbered 96, with 86 giving costs of \$26,033,000; ten alterations are to cost \$1,765,000 and 15 nurses' homes will come to \$2,658,000. Included in the totals this month are several projects of \$1,000,000 or more.

"Patient" **COMFORT** is all important

Only the **comfortably** heated hospital can deliver full value in service to the patients and also to the medical and nursing staff. Hence, good heating is of paramount importance in the administration of hospitals. The desired supply of heat to the heating system must be determined by the variable demands of the weather.

The Flexible Steam of Dunham Differential Heating

The Dunham Differential Vacuum Heating System circulates "Flexible" steam which is automatically varied in both temperature and vol-

ume to exactly meet **quickly** all the vagaries of the weather.

This is flexibility and adequacy far beyond the range and mechanical ability of the ordinary heating system. And the resulting economy sets a new standard, both in thrifty fuel use and in manpower costs for supervision and maintenance.

A request on your business letterhead will bring you complete technical data. C. A. Dunham Company, 450 E. Ohio Street, Chicago 11, Illinois.

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DUNHAM

DIFFERENTIAL HEATING
CHICAGO • TORONTO • LONDON

What's New for Hospitals

AUGUST 1945 SUPPLEMENT TO THE MODERN HOSPITAL

Brodny Urethrographic Clamp

The Brodny Urethrographic Clamp was designed to improve the method used in urethrography in the male. When the clamp is used the operator's hands are not exposed to the x-ray and there is no difficulty in obtaining a satisfactory grasp on the glans penis and retaining it until the films have been developed and the results checked. The clamp can also be adapted for the injection of measured quantities of medication into the urethra. (Key No. 2693)

Clay-Adams Co., Inc., Dept. MH, 44 E. 23rd St., New York 10

Blower Fan Control

Thermdrive is a thermally operated pulley designed to control the speed of a blower fan to produce even temperature in warm air heating and air conditioning equipment. The device can smoothly and gradually change the speed of a belt drive pulley as much as 70 per cent. A simple, compact unit consisting of but four parts, Thermdrive is attached to the drive and even greater speed change is possible when another unit is used on the driven shaft. The entire mechanism is rust resistant. (Key No. 2699)

Webster Electric Co., Dept. MH, Racine, Wis.

Flame Photometer

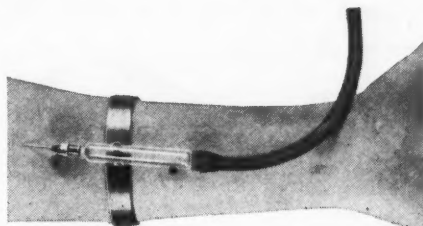
The new Perkin-Elmer Flame Photometer has been developed to improve the method of quantitative determination of sodium or potassium in the presence of other elements. The new instrument permits direct reading and quantitative determination of sodium and potassium individually in the presence of each other and of all other common elements. Less than two minutes is required for a routine analysis for both elements when an accuracy of plus or minus 3 per cent is satisfactory and slightly longer for greater accuracy. The operation of this device is relatively simple so that highly trained personnel is not required. (Key No. 2745)

Perkin-Elmer Corp., Dept. MH, Glenbrook, Conn.

Intravenous Clamp

A new device has been designed by Major Louis K. Pitman of the Army Medical Corps which should prove of considerable interest to hospitals. Known as the Amsco-Pitman Intravenous Clamp and manufactured by the American Medical Specialties Company, Inc., the clamp is designed for holding the needle in place in intravenous medication.

The device consists of a simple clamp which fits comfortably around the fore-



arm without constricting the blood supply and a smaller clamp mounted on a swivel which also allows some forward and backward movement and is attached to the larger clamp. The small clamp holds a glass tube into which the needle is fitted. The needle is kept in a steady position and the use of adhesive tape is eliminated. The clamp can be put in place and removed quickly and easily. (Key No. 2684)

American Medical Specialties Co., Inc., Dept. MH, 12 E. 12th St., New York 3

Plastic Label Glaze

A plastic protective glaze for coating over labels on bottles and other containers in the laboratory or pharmacy has been developed by Eimer and Amend. This Label Glaze provides a clear, protective coating that withstands moisture, is resistant to laboratory atmosphere and does not peel or discolor. (Key No. 2698)

Eimer & Amend Co., Dept. MH, 633 Greenwich St., New York 14, N. Y.

Clad Protective Creams for X-Ray Processing

Clad wet and dry protective creams for use in processing of x-ray films are designed to prevent accumulation of finger mark flaws during development

of negatives. The use of Clad dry cream leaves no stain while handling the film and the wet type of Clad is used for the dark room to prevent leaving a stain on the film. Processing stains on operators' hands are also reduced by the use of these creams. (Key No. 2740)

B. F. Goodrich Co., Dept. MH, Akron, Ohio

"Bobbin Wound" Catgut Sutures

A new line of "bobbin wound" Thermo-flex catgut sutures has been announced by Davis & Geck. Heat sterilized in hermetically-sealed glass tubes, the new line is designed for use with surgical stitching instruments.

Sutures range in size from 5-0 to 2, are of standard length, wound on stainless steel bobbins to fit either of the standard surgical stitching instruments, and are available in both plain and chromic catgut. The especially designed tubes permit the use of an individual bobbin without affecting the asepsis of the two remaining. (Key No. 2645)

Davis & Geck, Inc., Dept. MH, 57 Willoughby St., Brooklyn 1, N. Y.

Portable Fire Extinguisher

The Alfite Speedex is a new, fast-acting, portable fire extinguisher made in three different sizes. Carbon dioxide is used as the fire extinguishing agent. The operating valve is directly above the carrying handle and is instantly opened by pressure on the hand grip. (Key No. 2702)

American-LaFrance-Foamite Corp., Dept. MH, Elmira, N. Y.

Multi-Purpose Food

Richen is a food product which can be used to augment certain dishes, such as soups, casserole dishes, meat loaf, and similar items, by providing vitamins and minerals. The product contains iron, calcium, protein and several vitamins. It was developed to add nutritive quality to low cost foods. (Key No. 2682)

The Pickwick Co., Dept. MH, 3614 Council St., Los Angeles 4, Calif.

Instrument Table

An adjustable-height surgical instrument table made from aluminum with a special finish resistant to antiseptics,



chipping, cracking and darkening has been announced by the Aircraft Specialties Company. All joints are smoothly welded and polished to provide seamless round corners for easy cleaning of this ASCO Mayo type instrument table. The height is adjustable by a simple thumb screw from 54 inches maximum to a low of 30 inches. There is a heavy removable aluminum tray and the table is equipped with casters and with corrosion-resistant zinc glides at the tips of the base bars. It is electrically grounded for added safety. (Key No. 2739)

Aircraft Specialties Co., Dept. MH, 601 S. Anderson, Los Angeles 23, Calif.

Walker for Amputees

An invalid walker with a socket attachment has been developed for use by amputees. The walker is so designed that the stump can be placed in the socket and the patient can get around without the use of crutches while the stump is healing and shrinking. The walker is made of wood with double bottom flexible crutch tips and a leather socket. It is also designed to aid the patient in learning to walk with an artificial limb. (Key No. 2741)

Ray Trautman & Son, Dept. MH, 410 Sixth Ave. So., Minneapolis 15, Minn.

Prefabricated Door Unit

The Roddiscraft Door Unit is a new prefabricated door unit which is ready for immediate installation. Completely factory finished and accurately manufactured to size, including the door, jams, stops and casings, and put together with the hardware applied, the unit can be quickly installed with simple tools. It is manufactured to architects' details for perfect fitting and is a durable, permanent product which will retain tight

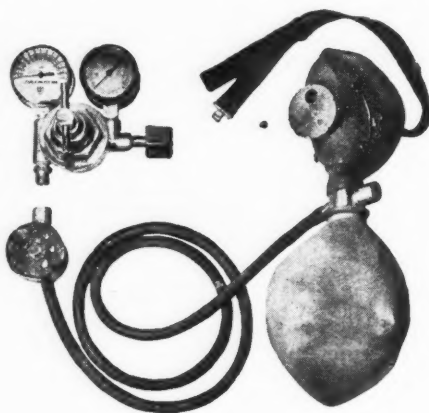
joints and ensure satisfactory operation. (Key No. 2690)

Roddiss Lumber & Veneer Co., Dept. MH, Marshfield, Wis.

Positive Pressure Mask

The O.E.M. Positive Pressure Mask is designed for the simple and inexpensive administration of oxygen in controlled percentages of from 40 to 100 per cent with or without positive pressure on expiration. The gum rubber face piece fits comfortably over the nose, mouth and chin and provides a complete air seal. The rubber headband is adjustable.

The desired concentration of oxygen is preset on the meter to assure the



same concentration of oxygen throughout the treatment. Automatic valves eliminate resistance and rebreathing. The face pieces are interchangeable and the unit may be used with helium-oxygen mixtures. (Key No. 2743)

Oxygen Equipment Mfg. Co., Dept. MH, 405 E. 62nd St., New York 21

Magnifying Light

Super Sight is the name of a new light which is combined with a magnifying lens for use in examinations, surgery, treatments and other work requiring magnification and light. Made in both clamp and floor stand models, the light is furnished in either white or bronze finish. Lenses either four or five inches in diameter are available and the unit can be easily moved about as needed, remaining in any position desired. It is particularly suited to removal of foreign bodies from the eyes or skin, for first aid treatment and for special surgery. (Key No. 2577)

Boyer-Campbell Co., Dept. MH, 6540 Antoine St., Detroit, Mich.

Fluorescent Lampholder

The Twin Turret fluorescent lampholder is new in design and construction and holds lamps securely in contact. Made for use with two 40 watt lamps, the holder has starter sockets as an integral part of its construction. The lampholder can be mounted on any flat surface with two screws and the wiring process is greatly simplified. A new design for inserting and removing lamps adds to the efficiency of the unit. (Key No. 2700)

General Electric Co., Dept. MH, Bridgeport, Conn.

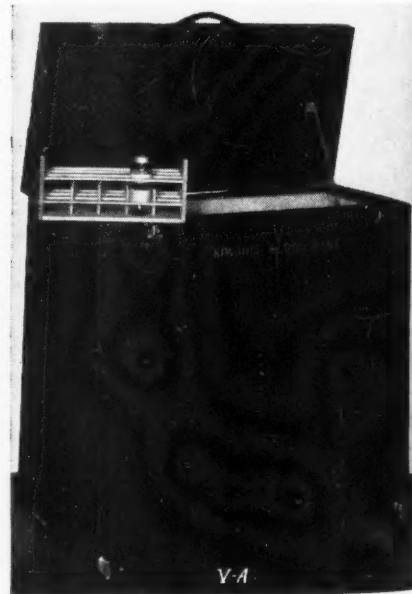
Laboratory Filter

A new laboratory filter of the pyrogen and bacterial retentive type has been developed with a mechanical design which permits double filtration in series. Made of bronze plated materials or entirely from stainless steel, the unit has a built-in stone fiber eliminator through which all filtrate must pass. The filter is available in 4 inch and 8 inch diameter. The 8 inch unit will filter one liter of aqueous solution in 15 minutes at 10 pounds pressure. (Key No. 2567)

Ertel Engineering Corp., Dept. MH, Kingston, N. Y.

Plasma Storage Cabinet

The Model VA blood plasma cabinet has been developed for plasma storage. Powered by a 1/4 HP reciprocating type



condensing unit using Freon refrigerant, the entire refrigerator and refrigerating mechanism is mounted on rubber tired

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casters for easy portability and the mechanism can be plugged in at any ordinary light socket. The over-all size of the unit is 41 inches high, 21 inches deep and 43 inches wide. The inside refrigerated container is 35 by 18 by 12 inches, or 4 cubic feet. (Key No. 2736)

Gennett & Sons, Inc., Dept. MH, Richmond, Ind.

Eggcrate Aristolite Luminaire

The new Eggcrate Aristolite fluorescent luminaire is designed for four 40 watt fluorescent lamps. The strong, rigid eggcrate louvers shield the lamps in the center portion of the fixture and carry out the V design. It is a combination of half glass-diffusing and half eggcrate-shielding which provides efficient down lighting plus diffused side lighting. The unit is designed for individual or continuous installation and can be suspended from the ceiling or mounted flush. (Key No. 2622)

Edwin F. Guth Co., Dept. MH, 2615 Washington Ave., St. Louis 3, Mo.

Improved Clamp for Laryngectomy

The Vasconcelos-Barretto Clamp is an improvement on the Vasconcelos Clamp for use in surgery of the larynx. Especially devised for the suturing of the pharynx, the improved clamp has teeth in both blades instead of only one. This aids in preventing the escape of the pharyngeal mucosa when the larynx is removed. The clamp has been developed by Doctors Vasconcelos and Barretto of São Paulo, Brazil. (Key No. 2578)

George P. Pilling & Son Co., Dept. MH, Arch & 23rd Sts., Philadelphia 3, Pa.

Plastic Impregnated Textiles

Plastic coated fabrics, made with synthetic resin compositions and called "Fabrilite," have been developed by E. I. du Pont de Nemours and Company. They can be heat sealed or cemented, given colors or embossed on the surface. The materials are flexible, light weight, strong, resist perspiration, abrasion, cracking or shrinking, stains and food chemicals, are washable and can be cut and stitched. Now made for military use, the fabric will have many postwar uses including hospital sheeting. (Key No. 2565)

E. I. du Pont de Nemours & Co., Inc., Dept. MH, Wilmington 98, Del.

PHARMACEUTICALS

Pancreatin Granules

Panteric Granules are enteric coated pancreatin granules containing the starch, protein and fat digesting enzymes amylase, trypsin and lipase. Indicated in treatment of indigestion and food allergy due to pancreatic hypofunction they have also been found of value in treatment of celiac disease resulting from pancreatic insufficiency.

Available in one and four ounce bottles, each with a small measuring spoon for convenience in administration, the granules are practically tasteless and may be taken with water or milk or sprinkled on food. The product is also available as Panteric Capsules, Panteric Tablets and Panteric Compound Tablets. (Key No. 2708)

Parke, Davis & Co., Dept. MH, Detroit 32, Mich.

Ascorbic Acid

The Upjohn Company has announced Ascorbic Acid in 100 mg. and 500 mg. sterile solution for use in rapid tissue saturation with vitamin C. The product can be used intravenously or intramuscularly and both sizes are available in boxes of 6 and 25 ampules. (Key No. 2749)

Upjohn Co., Dept. MH, Kalamazoo 99, Mich.

Globin Insulin

"Wellcome" Globin Insulin with Zinc is now available in a new strength, 40 units in one cc. in vials of 10 cc. The new strength has been developed for milder cases of diabetes where fewer units are needed for control. A distinctive red and tan label identifies this strength. (Key No. 2747)

Burroughs Wellcome & Co. (U.S.A.) Inc., Dept. MH, 11 E. 41st St., New York 17

Diethylstilbestrol Dipalmitate

A new form of estrogenic treatment for premenstrual tension, menopausal symptoms and similar conditions is offered in Diethylstilbestrol Dipalmitate. A compound of diethylstilbestrol and palmitic acid in peanut oil, the active constituent is slowly absorbed and the resulting estrogenic effect is prolonged. It is designed for intramuscular injection only and is offered in 1 cc. sterile ampules in boxes of 6 and 25. (Key No. 2526)

Abbott Laboratories, Dept. MH, North Chicago, Ill.

RECENT CATALOGS AND BOOKLETS

- A booklet which should prove invaluable in the teaching hospital has been developed by Ethicon Suture Laboratories, Div. of Johnson & Johnson, New Brunswick, N. J. The book demonstrates the various steps in the formation of the important surgical knots and copies of this "Ethicon Manual of Surgical Knots" are available for all of your students. (Key No. 2756)

- The lifting of W.P.B. restrictions on the manufacture of stainless steel or enameled hospital equipment brings an attractive bulletin from S. Blickman, Inc., Weehawken, N. J., illustrating and describing the "Conqueror Line of Hospital Equipment." (Key No. 2754)

- Flush valve application data as related to hospitals are presented in an interesting bulletin recently issued by Imperial Brass Mfg. Co., 1231 W. Harrison St., Chicago 7, entitled "Architects' Views on Flush Valve Applications." (Key No. 2662)

- A new 20 page booklet describing and illustrating the complete line of resuscitation apparatus designed by Doctor Kreiselman and manufactured by the Heidbrink Division, Ohio Chemical & Mfg. Co., 745 Hanna Bldg., Cleveland, Ohio, has recently been released under the name "Kreiselman Resuscitators and Bassinets." (Key No. 2715)

- The Norton Door Closer Co., 2900 N. Western Ave., Chicago 18, has recently issued its new "Wartime Catalog No. 22W-2" giving full information and prices on Norton Door Closers and parts. (Key No. 2716)

- Two new descriptive pamphlets on the Kewanee Garbage Burner designed to save fuel for heating water and the Tabasco Hot Water Supply Heaters have recently been released by Kewanee Boiler Corp., Kewanee, Ill. (Key No. 2765)

- Nurokardiac "Rorer" and its use in the treatment of cardiac neuroses are described in a pamphlet which includes indications for its use and action of the product. The pamphlet is issued by William H. Rorer, Inc., Philadelphia 6, Pa. (Key No. 2764)

- A new bulletin, Form 766, describing and illustrating "Kellogg PAX Telephone Systems," has been received from Kellogg Switchboard & Supply Co., 6650 S. Cicero Ave., Chicago 38. The many uses for an inter-communication system of this kind are suggested together with information on its operation. (Key No. 2667)

• "Control of Odor and Freshness Indoors" is the title of a manual on the Airkem Chlorophyll Air Freshener. The various needs, uses and methods of application of the product in the air conditioning system are covered with information designed to help the administrator or engineer understand the function of this deodorizing product and air freshener, to plan the installation of the equipment and to estimate the amount of Airkem needed. The manual has been prepared by W. H. Wheeler, Inc., 234 E. 46th St., New York 17. (Key No. 2636)

• Lyon Sectional Kitchens for institutional installation are described in an attractive folder issued by Lyon Metal Products, Inc., Aurora, Ill. (Key No. 2731)

• A second edition of the "Therapeutic Reference Table, Penicillin-C.S.C." has been prepared by the pharmaceutical division of Commercial Solvents Corp., 17 E. 42nd St., New York 17. Indications, modes of administration and dosages recommended, duration of treatment required and collateral therapy are covered. (Key No. 2701)

• Sedgwick Standard Specifications for Elevators and Dumb Waiters" are offered in a new 24 page booklet issued by Sedgwick Machine Works, 150 W. 15th St., New York 11. The booklet is designed to facilitate the writing of specifications and to serve as an indication of the extent of the Sedgwick line of elevators and dumb waiters. (Key No. 2639)

• An engineering handbook containing sketches, charts, dimension prints and instructive text for the proper application and performance of air diffusers has been prepared by the W. B. Connor Engineering Corp., 116 E. 32nd St., New York 16. Entitled "Kno-Draft Adjustable Air Diffusers," the many pages of informative material are bound in a loose-leaf portfolio. (Key No. 2593)

• Various types of valves for sterilizers, refrigeration equipment, cookers, heating equipment and many other uses in hospitals are described and illustrated in the recently issued 28 page catalog of the A. W. Cash Valve Mfg. Co., Decatur, Ill. (Key No. 2594)

• "Precision" Safety Heaters for heating complex laboratory glassware set-ups involving distillation columns, flasks, reflux condensers and other glassware are described and illustrated in Bulletin HP-1650 recently issued by Precision Scientific Co., 1750 N. Springfield Ave., Chicago 47. (Key No. 2587)

• Full color illustrations of "The Hands in Arthritis" are featured in a booklet so entitled. Descriptive information is included as well as x-ray studies of the same deformed hands followed by a helpful bibliography on the subject. The booklet was prepared by the Medical Department of Nutrition Research Laboratories, 4210 Peterson Ave., Chicago 30. (Key No. 2640)

• A 12 page booklet on "Ellison Balanced Doors" has recently been issued by Ellison Bronze Co., Inc., Jamestown, N. Y. Full information on this new and modern type of entrance door is presented including detailed drawings, specifications, illustrations and a list of installations. (Key No. 2607)

• Three new types of ADSCO heaters and coolers with dimensions, capacity tables and list prices on units suitable for special use are described in a new 12 page loose-leaf Bulletin No. 35-76B recently issued by American District Steam Co., North Tonawanda, N. Y. (Key No. 2637)

• Information on Refrigerated Food Lockers is available in detail in Bulletin 145-F recently issued by the Frick Co., Waynesboro, Pa. (Key No. 2718)

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Bessie Covert,
Editor, "What's New for Hospitals"

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